PALLIATIVE & END-OF-LIFE CARE · MENTAL CAPACITY · PRIMARY CARE

Advance Care Planning

A plain-English guide for GP trainees and international medical graduates. What advance care planning (ACP) is, who it helps, and the one distinction that trips people up: **which written plans are only wishes, and which are legally binding.**

◆ **The one idea to hold onto**

ACP belongs to the **person**, not the clinician. It is **voluntary**, **personalised**, and built over several conversations — not a single form. Some outcomes are only wishes that guide us; others — a valid ADRT, or a registered Health & Welfare LPA — are **legally binding**. Knowing which is which is the core skill of this topic.

The same conversation can produce plans with very different legal weight.

WHAT'S INSIDE

1 What advance care planning really is

ACP is a **voluntary** series of conversations between a person and those caring for them — about what matters to them and how they want to be cared for in the future — made **while they still have the capacity to decide**. Three truths shape every conversation.

IT'S THEIRS

The person leads

They can start it, pause it, hand it over, or stop it whenever they wish. No one may be forced into ACP.

OVER TIME

Not a single form

It is a process, rarely one conversation. Even after an emergency forces a quick decision, offer to revisit it.

OPTIONAL

Declining is valid

Not everyone wants these talks. Respect that, record it, and gently offer again another day.

The four things an ACP conversation can produce

One conversation, up to four different records. Notice how the legal weight changes as you move down.

WISHES

Advance statement

What matters to me: my values, priorities, and a named spokesperson if I want one.

✓ **Not binding · guides best interests**

REFUSAL

ADRT

A refusal of specific treatment(s) in specific situations, decided in advance.

▲ **Binding if valid & applicable**

PROXY

LPA — Health & Welfare

A trusted person appointed to decide for me if I lose capacity.

▲ **Binding once registered**

EMERGENCY

ReSPECT / DNACPR

Clinical recommendations for a future crisis, including whether to attempt CPR.

✓ **Not binding · a recommendation**

◎ **A picture that sticks**

Think of ACP as writing the person's plan for a journey they may not be awake for. The **advance statement** is a note on the dashboard saying where they'd like to go and what they enjoy. An **ADRT** is a locked "do not drive down this road" sign the driver must obey. An **LPA** hands the wheel to someone they trust. **ReSPECT** is the co-driver's crib sheet for a sudden emergency. Same journey — very different authority.

2 Which plans must you follow?

This is the distinction that examiners, and coroners, care about most. Get it right and you protect both the **patient's wishes** and **yourself**.

The plan	What it is	Legally binding?	The rule to remember
Advance statement	The person's wishes, values and preferences.	**No**	Must be taken into account in any best-interests decision.
ReSPECT / DNACPR	Clinical recommendations for an emergency, incl. CPR.	**No**	A recommendation, not consent. CPR cannot be demanded if it will not work — but you must discuss it.
ADRT	An advance refusal of a named treatment.	**Yes — if valid & applicable**	You must follow it. Overriding a valid ADRT is unlawful.
LPA — Health & Welfare	An appointed proxy decision-maker.	**Yes — once registered**	May consent to or refuse treatment; life-sustaining treatment *only* if the LPA says so.

▲ **The ADRT rule you must not get wrong**

A **valid and applicable** ADRT has the same legal force as a refusal by a person with capacity. **You must not override it — even to save life.** To refuse **life-sustaining** treatment, the ADRT must be: in writing; signed by the person (or on their behalf, in their presence); signed by a witness; **and** state that it applies *"even if life is at risk."*

Source: Mental Capacity Act 2005, ss.24–26; MCA Code of Practice, Chapter 9.

✓ **When an ADRT does NOT apply**

Treat in the person's **best interests** if: the ADRT is unclear or does not fit the situation; the person later did something clearly inconsistent with it; a **newer registered LPA** covers the same treatment; or you have reasonable doubt about its validity. When genuinely in doubt, **treat to preserve life while you seek advice** — including the Court of Protection if needed.

◆ **The LPA in one paragraph**

Only a **Health & Welfare** LPA can make treatment decisions — a Property & Financial Affairs LPA cannot. It works only **after registration** with the Office of the Public Guardian, and only once the person **lacks capacity**. An attorney can refuse or consent to treatment but **cannot demand** treatment that is not clinically indicated. **What's new:** the Powers of Attorney Act 2023 is moving LPAs to a digital "make-and-register" service with identity checks. **Source:** Powers of Attorney Act 2023; OPG.

3 Capacity: the ground everything stands on

Every ACP decision rests on capacity. Capacity is **decision-specific** and **time-specific** — a person may be able to decide one thing but not another, and able today but not tomorrow.

The five statutory principles

1	2	3	4	5
Assume capacity	**Support the decision**	**Unwise ≠ incapable**	**Best interests**	**Least restrictive**
until shown otherwise	every practicable help	a foolish choice is allowed	if they lack capacity	option that limits least

The five principles of the Mental Capacity Act 2005 (section 1).

▸ **"Best interests" is not "what the doctor would choose"**

Work through the MCA checklist: the person's **past and present wishes**, their **beliefs and values**, and the views of family, carers, and any attorney or IMCA. Remember: a **valid ADRT still overrides** a best-interests decision to treat.

◆ **Reduced capacity is not zero say**

Someone who cannot make the *whole* decision may still express clear preferences — and these **must** shape their care. Consult those close to them. If there is no suitable person for a serious decision, you **must instruct an Independent Mental Capacity Advocate (IMCA)**.

The four-part capacity test — can the person…

- ✓ **Understand** the information relevant to the decision?
- ✓ **Retain** it long enough to make the decision?
- ✓ **Weigh** it up as part of deciding?
- ✓ **Communicate** their decision (by any means)?

Failure on *any one* of these — *because of* an impairment of mind or brain — means the person lacks capacity for *that* decision, at *that* time. *(MCA 2005, ss.2–3.)*

4 Who should be offered ACP?

Offer ACP to **anyone who wants to plan ahead** — and **actively** to those whose health may decline or who may lose capacity.

◎ **A simple prompt to open the door**

Ask yourself the **surprise question**: *"Would I be surprised if this person died within the next 12 months?"* If the answer is **no**, that is your cue to gently begin the conversation.

Actively offer ACP when you see...

- **Progressive, life-limiting illness** — dementia, frailty, advanced cancer, or failing organs (heart, kidney, liver, lung), and progressive neurological disease.
- **Declining function or rising symptoms** — a heavier burden of illness, or repeated hospital admissions.
- **A change of direction** — a shift toward palliative care, or a move into a care home.
- **Major surgery or high-risk treatment** — for example, a bone marrow transplant.
- **Acute, life-threatening illness** that may not fully reverse.

Why it is worth the time — for everyone

THE PERSON

Control & a voice

Care that fits what matters to them, a clearer view of what treatment can and can't do, and confidence their voice is heard in a crisis.

FAMILY & CARERS

Less weight to carry

Reassurance the person shaped their own care — and far less burden of deciding blind, under pressure, in a difficult moment.

TEAM & SYSTEM

Safer, calmer care

More confident decisions, fewer unwanted interventions, less conflict, and resources used where they genuinely help.

◆ **The evidence behind the effort**

The whole national push for consistent ACP grew from the CQC's 2021 review, *Protect, Respect, Connect*, which found that good conversations were too often replaced by rushed or blanket decisions during the pandemic. Done well, ACP is how we prevent that.

5 The six universal principles

NHS England and a coalition of **28 organisations** agreed six principles for good ACP in England. Together they answer one question: **what does "good" look like?**

1 The person is at the centre

They decide **who else is involved**, and they can change their plan — or their mind — **at any time**. People are ready at different moments; some never want the conversation, and that must be respected and recorded.

2 Conversations are personalised

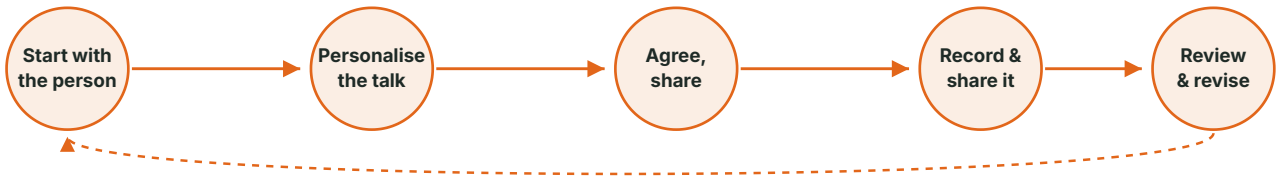
Start with **what matters to them** and what a good life looks like. Be **honest** about what is and isn't possible. Match your pace and language to the person — use **trained interpreters, never family**, and adjust for sensory or cognitive needs.

3 Outcomes are shared decisions

Blend the person's priorities with the professional's knowledge of the illness. A person with capacity **may refuse** treatment you would advise. Clinicians **need not offer** treatment that will not help — but must **explain why**, never by blanket rule, and **offer a second opinion** if there is disagreement.

▸ **The thread running through all six**

Every principle points the same way: **the person owns the process.** Our job is to inform, to listen, to be honest about limits, and to record and honour what we agree — so their voice still speaks when they cannot.



A loop, not a line — the plan is revisited as things change.

5 The six principles — continued

Principles four to six turn a good conversation into a plan that **travels with the person** and stays useful over time.

4 The plan is shareable

Record it in the person's **own words**. Capture any **ADRT, DNACPR, ReSPECT, or LPA**. Then — **with their consent** — share it so GP, ambulance, out-of-hours, hospital and care teams can all see it the moment it counts. A plan no one can find is a plan that fails.

5 The plan is reviewed

Encourage updates when things change — a deterioration, an admission, or a shift in what matters. Decisions made during a **short-term illness** can be revisited once it settles. Keep **ADRTs current** so they remain valid and applicable when needed.

6 Anyone can speak up

The person, their family, or any member of staff must be able to **raise concerns** if these principles are not being followed — through a clear, well-publicised route. Speaking up is part of good care, not a complaint against it.

◆ **What's changed from older teaching**

Then: a DNACPR could be treated as a clinician's tick-box, sometimes applied to whole groups. **Now:** it is one small part of a **person-led** plan, and blanket decisions are **unlawful**.

Then: "living wills." **Now:** the **Advance Decision to Refuse Treatment (ADRT)**, with clear legal tests.

Then: emergency wishes scattered across forms. **Now: ReSPECT (version 3)** holds them in one place, framed around the person's goals of care.

Then: paper-only LPAs, slow to register. **Now:** a **digital make-and-register service** with identity checks (Powers of Attorney Act 2023).

▸ **Where ACP sits in the bigger picture**

ACP is the **future-facing** part of personalised care and support planning. The same skills — listening, honesty, shared decisions — apply to care *now*. For the dying phase specifically, follow **NICE NG31** (care of dying adults) alongside these principles.

6 Getting it right: five traps to avoid

Most ACP failures are not clinical — they are process errors. These five cause the most harm, and the most complaints.

TRAP 1

Blanket decisions

A DNACPR or treatment limit must **never** rest on age, disability, care setting, or a diagnosis alone. Every decision is individual. This was the core failing the CQC found in COVID.

TRAP 2

Family as interpreters

For these conversations, **use a trained interpreter** — not a relative. Family may soften, filter, or reshape what is said, and cannot give the person a private voice.

TRAP 3

Treating it as a form

ACP is a **process**, not a one-off signature. A form completed without conversation, and never revisited, does not serve the person.

TRAP 4

"Not binding = ignore"

An advance statement and a DNACPR/ReSPECT recommendation are **not** legally binding — but they **must still guide** your decisions. They are evidence of what the person wants.

▲ **Trap 5 — treating capacity as all-or-nothing**

Capacity is **specific to the decision and the moment**. Do not carry a single label ("confused", "has dementia") across every choice. **Reassess** for the actual decision, at the actual time, and support the person to take part as far as they can.

✓ **The safe default in an emergency**

If you are called to a crisis and there is **no clear, valid plan** in front of you, or you are in genuine doubt: **act to preserve life** and treat in the person's best interests while the facts are established. A registered LPA or a valid ADRT changes this — but uncertainty does not.

▸ **Safety-netting the conversation**

Close every ACP discussion by agreeing **three things**: where the plan is **recorded**, **who** it will be shared with, and **when** it will be reviewed. Tell the person they may change any of it, at any time.

Teaching aid — not clinical guidance. Sources: CQC (2021); NHS England (2022); Mental Capacity Act 2005; GMC, *Decision making and consent* (2020). Verify against current guidance and local policy before use.

7 One-page recall

If you remember nothing else, remember this. Cover the page, and try to reconstruct each line from memory — that is how it sticks.

Advance Care Planning — the essentials

- **What it is:** a voluntary, person-led conversation about future care, held while the person has capacity — over time, not a single form.
- **Four possible outputs:** advance statement (wishes) · ADRT (a refusal) · LPA Health & Welfare (a proxy) · ReSPECT/DNACPR (emergency recommendations).
- **Legally binding:** a valid & applicable **ADRT**, and a **registered Health & Welfare LPA**. **Not binding:** advance statement, ReSPECT/DNACPR.
- **ADRT for life-sustaining treatment:** written · signed · witnessed · states *"even if life is at risk."*
- **Capacity:** assume it → support it → unwise ≠ incapable → best interests → least restrictive. It is decision- and time-specific.
- **The golden rule:** never make blanket decisions. When in doubt in a crisis, preserve life and treat in best interests.

Quick self-test

- Which two outputs are **legally binding**?
- What **four** features make an ADRT valid for life-sustaining treatment?
- Can a **Property & Financial** LPA refuse chemotherapy? (No.)
- A patient makes an "unwise" choice. Do they lack capacity? (Not on that alone.)

Red flags to act on

- A DNACPR justified only by **age or diagnosis**.
- A **family member interpreting** a capacity or EoL talk.
- A valid ADRT being **overruled** to treat.
- A serious best-interests decision with **no IMCA** where the person is unbefriended.

◎ **The sentence to carry into clinic**

"Some plans **guide** me; some plans **bind** me — and my first job is always to know **which is which**, and to make sure the person's voice is in the room even when they cannot be."

8 Glossary & sources

The terms you will meet on the ward, in the notes, and in the exam.

ACP — Advance Care Planning. A voluntary process of discussion about future care, made while the person has capacity.

Advance statement. A record of wishes, values and preferences. Not legally binding, but guides best-interests decisions.

ADRT — Advance Decision to Refuse Treatment. A legally binding refusal of a named treatment (MCA 2005, ss.24–26), valid only if the strict tests are met.

Best interests. The framework for deciding for a person who lacks capacity — weighing their wishes, beliefs, and the views of those close to them.

Capacity. The decision- and time-specific ability to understand, retain, weigh and communicate a decision.

DNACPR. A recommendation that CPR not be attempted. A clinical decision, not legally binding, and never a blanket rule.

IMCA — Independent Mental Capacity Advocate. A statutory advocate for people who lack capacity and have no one suitable to consult on serious decisions.

LPA — Lasting Power of Attorney. A registered legal appointment. Only a *Health & Welfare* LPA can make treatment decisions.

MCA 2005 — Mental Capacity Act. The law governing decisions for those who may lack capacity in England & Wales.

ReSPECT. Recommended Summary Plan for Emergency Care and Treatment (v3) — records emergency recommendations, including CPR.

TEP / ECTP. Treatment Escalation Plan / Emergency Care & Treatment Plan — clinician-led plans guiding care if a person deteriorates.

Surprise question. "Would I be surprised if this person died within 12 months?" — a prompt to begin ACP.

Key sources & further reading

Guidance & law

- NHS England — *Universal Principles for Advance Care Planning* (2022).
- Mental Capacity Act 2005 & Code of Practice (ss.1–4, 24–26; Ch.9).
- Powers of Attorney Act 2023 — LPA modernisation.
- GMC — *Decision making and consent* (2020); *Treatment and care towards the end of life*.

NICE & specialist

- NICE NG142 — end-of-life care for adults (service delivery).
- NICE NG31 — care of dying adults in the last days of life.
- NICE NG197 — shared decision making; NG108 — decision-making & mental capacity.
- Resuscitation Council UK — the ReSPECT process (version 3).

◆ **How to use this aid**

Teach from the diagrams; test with the recall card. The single highest-yield message for trainees and IMGs is the **legal spine on page 3** — which plans guide, and which plans bind.