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Appendix 1

## Policy for supporting Service Users in completing an advance statement

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Type of document	Policy
Target audience	All CWP staff
Document purpose	<p>This document provides guidance to staff in supporting service users who wish to make an advance statement. It contains a suggested advanced statement template.</p> <p>An advance statement is a way of service users making their views known when they are well, on how they would like to be treated during a crisis when they may be unable to make informed choices.</p> <p>An advance statement should not be confused with an Advance Directive, that can be made in accordance with the provisions of the Mental Capacity Act 2005 (MCA 2005), which relates to the anticipatory refusal of medical treatment and is legally binding.</p>

Approving meeting	Patient Safety and Effectiveness Sub Committee	Date 25/02/2016
Implementation date	Followed by an annual compliance review	

CWP documents to be read in conjunction with	
	Advance Statement/Advance Statement Leaflet

Document change history	
What is different?	Reviewed by task and finish group to ensure the language is more person centred
Appendices / electronic forms	Appendix 1 has been reviewed and updated.
What is the impact of change?	This new document will improve the uptake of Advance Statements and help to identify carers to support the Triangle of Care and New Care Act (2015)

Training requirements	Yes - Training requirements for this policy are in accordance with the CWP Training Needs Analysis (TNA) with Learning and Development (L&D)
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Document consultation	
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Financial resource implications	Yes Printing Costs
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External references
1. Mental Capacity Act
2. Richard Jones, Mental Health Act Manual, Seventeenth Edition (2014)
3. Triangle of Care

Equality Impact Assessment (EIA) - Initial assessment	Yes/No	Comments
Does this document affect one group less or more favourably than another on the basis of:		
- Race	No	
- Ethnic origins (including gypsies and travellers)	No	
- Nationality	No	
- Gender	No	
- Culture	No	
- Religion or belief	No	
- Sexual orientation including lesbian, gay and bisexual people	No	
- Age	No	
- Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
Is there any evidence that some groups are affected differently?	No	
If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable? N/A		
Is the impact of the document likely to be negative?	No	
- If so can the impact be avoided?	Select	
- What alternatives are there to achieving the document without the impact?	Select	
- Can we reduce the impact by taking different action?	Select	
Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted.		
If you have identified a potential discriminatory impact of this procedural document, please refer it to the human resource department together with any suggestions as to the action required to avoid / reduce this impact. For advice in respect of answering the above questions, please contact the human resource department.		
Was a full impact assessment required?	No	
What is the level of impact?	Low	

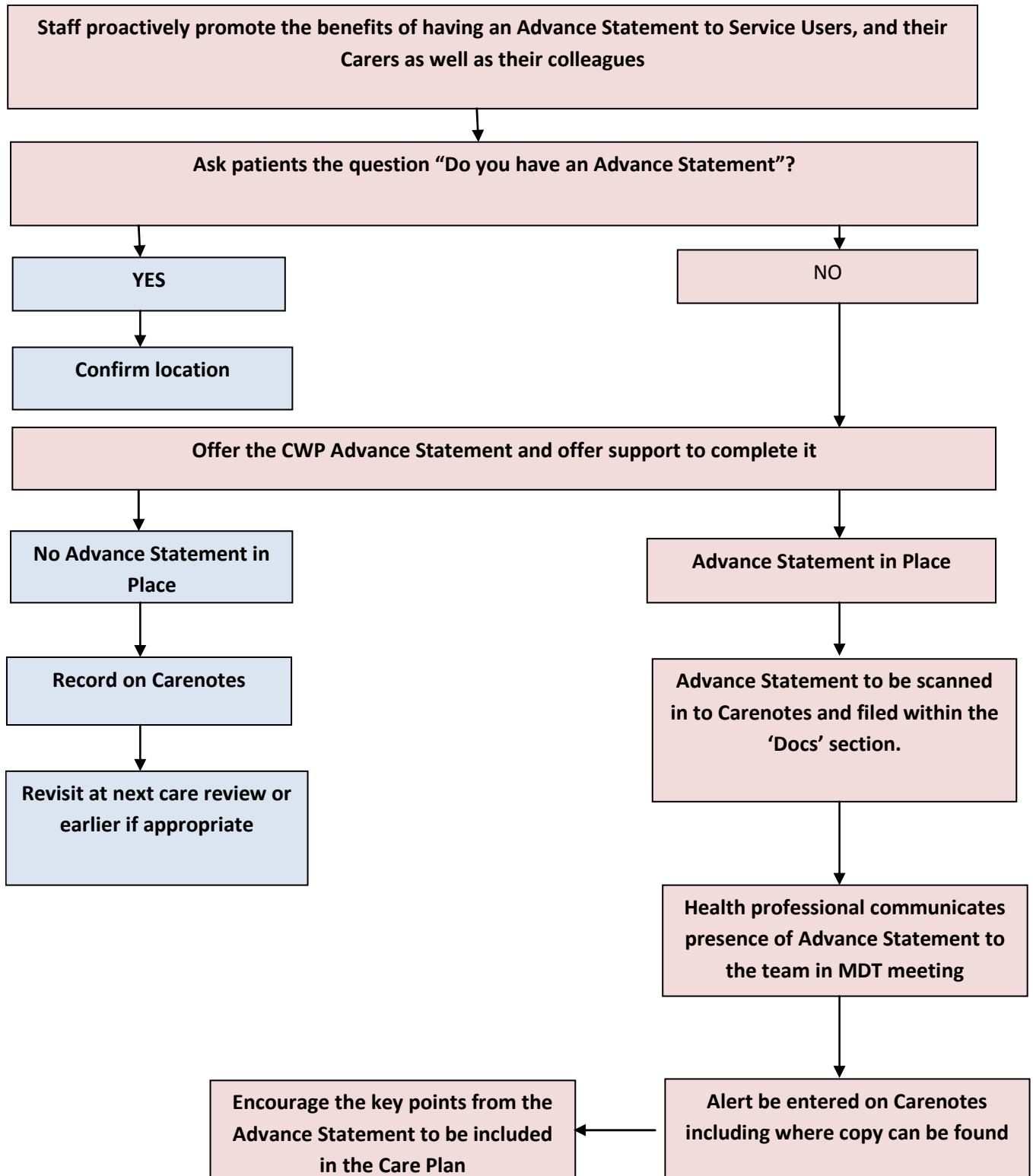
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Appendix 1 – Advance Statement Leaflet (and example Advance Statement template)

### Quick reference flowchart

For quick reference the guide below is a summary of actions required.



## 1. Introduction

An Advance Statement is a way of service users making their views known when they are well, on how they would like to be treated during a crisis when they may be unable to make informed choices. This applies to people in receipt of Cheshire and Wirral Partnership NHS Trust (CWP) services.

Staff should be involved in supporting service users in preparing advance statements and assisting them to follow the processes involved to ensure that their wishes can be met. Staff should also promote this to service users where they feel this is appropriate. This discussion in itself can promote collaboration and trust between service users and staff. An Advance Statement is not mandatory, or a legally binding document however it enables the service user to express their wishes in a collaborative approach. Staff should ensure that service users are aware of the benefits of having an advance statement. The Mental Health Act (2012) can override an Advance Statement however full collaborative care can still be provided taking into account service users wishes. In such cases when service users are subject to the Mental Health Act (2012) “the past wishes and feelings - so far as they are known – take on a greater significance” (Jones, 2014)

The new Care Act (2015) emphasises the importance of early identification of carers. The Triangle of Care (Carers Trust 2013 2<sup>nd</sup> Edition) also recognises the benefits of using an Advance Statement to identify main carers to ensure they are actively engaged and listened to at each stage of the assessment, treatment and discharge process. Issues around confidentiality are addressed in the Triangle of Care, and advocate a more inclusive approach encouraging staff to listen and act on carers concerns. This approach also sits well with the CWP Recovery Strategy and self-directed care.

Advance statements should also be considered by health and social care professionals where the service user has dementia. This should be done whilst the service user is assessed as having capacity and allowing them the opportunity to state what is to be done should they, subsequently, lose the capacity to decide or communicate a decision (NICE 2011).

An Advance Statement should not be confused with an Advance Directive, that can be made in accordance with the provisions of the Mental Capacity Act 2005 (MCA 2005), which relates to the anticipatory refusal of medical treatment and is legally binding.

## 2. Definitions

The following definitions are used in this policy:

### Advance Statement

An ‘Advance Statement ‘ is a document which can be drawn up with a service user when they have capacity in order to express their choices ‘in Advance’ about what they would like to happen with regard to their **medical, personal and home-life** should they become unwell or lack capacity\* in the future. Advance Statements can often be made in conjunction with Effective Care Co-ordination (ECC) documents.

\*Capacity - “a person has capacity if they can understand and retain the information relevant to the decision in question, can weigh that information in the balance and communicate their decision, (Mental Capacity Act 2005)

### **3. Advance Statements are made up of 6 parts**

#### **1. About me**

Your symptoms, history and anything that has worked well for you in the past. It is also an opportunity to tell us about what you are like when you are well.

#### **2. If I become unwell**

What you would like to happen if you become unwell, any triggers and signs to look out for when you are becoming unwell and anything that can make the situation worse.

#### **3. The people I would like to be informed and involved**

The people you would like to be kept informed and involved in discussions about your treatment and any changes in your treatment plan. For example your main carer(s).

#### **4. If I am admitted to hospital**

An opportunity to tell us about your individual needs and anything that would make your stay in hospital more comfortable and help your recovery.

#### **5. When I am discharged from hospital**

What you want to happen when you go home and who you want to support you in your recovery.

#### **6. What to do in a crisis and who to contact**

Outlines your crisis plan and the actions to be taken by you and your care team. This section includes essential contact numbers.

### **4. Duties and responsibilities**

#### **4.1 Chief Executive**

- Has overall responsibility for ensuring that the systems are in place to enable service users to make and submit advance statements. The Chief Executive has delegated responsibilities within an Executive Directors portfolio framework.

#### **4.2 Director of Operations**

- Has delegated Board level responsibility for ensuring that there are divisional processes in place to support staff and service users in the development and management of advance statements.

#### **4.3 Consultant Psychiatrist**

- To consider the content of an advance statement when planning treatment.
- Record reasons for deviating from key aspects of the advance statement

#### **4.4 Care Co-ordinator or other mental health professional**

- To explain the policy and the potential benefits of completing an Advance Statement to the service user and/or carer and provide support and leaflets as required. This can be done by utilising the guidelines that can be found in Appendix 1 of this policy.
- To actively advise and support the service user in considering the content of their Advance Statement if this is the service users wish.
- To consider the content of the Advance Statement when planning care and to follow the content as much as possible.
- To ensure there is a clear rationale if any points within the Advance Statement are not followed, as they are deemed not to be in a patient's best interest at that moment in time. This rationale must be agreed as an MDT, including the Care Co-ordinator, and the rationale must be discussed with the service user, and where appropriate their carer. The

rationale must be documented clearly within the person's Care Notes, and the decision reviewed regularly.

- To advise the service user to inform people of their responsibilities in the Advance Statement:
  - Inform their care co-ordinator, consultant psychiatrist, or other mental health professional that they wish to prepare an Advance Statement;
  - Inform the family, and/or carer of the existence of the Advance Statement;
  - Keep a copy of the Advance Statement

#### **4.5 All staff receiving an advance statement**

- To receive and file the Advance Statement by scanning the paper copy into the docs section of Carenotes.
- To register an alert on the electronic health record to the effect that an Advance Statement exists, where it can be found and the date of completion.
- If there is an identified carer, ensure this is flagged on the electronic health record.