



**Addresses**

**For Action**

GP Practices  
Chief Executives NHS Boards

**For information**

NHS Board Primary Care Leads  
Practice Manager Network  
Practice Nurse Network

**Policy Enquiries to:**

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10 April 2020

Dear Colleagues,

**ANTICIPATORY CARE PLANS FOR VULNERABLE AND HIGH RISK PATIENTS**

As you will know the Chief Medical Officer has [recently written to both General Practice](#) and to Hospital Clinicians about the plans for supporting those patients identified as being at the highest risk of mortality and severe morbidity from COVID-19.

In this letter clinicians were advised that patients in the vulnerable patients group would be written to over the next week with advice about Shielding (*Shielding is a measure to protect extremely vulnerable people from coming into contact with coronavirus, by minimising all interaction between them and others*), and where practice capacity allowed, those in the very high risk group would be contacted by their GP practice to have a further discussion.

The letter also recommended as that as part of this discussion with patients, important information, such as key worker, should be captured and included in the electronic Key Information Summary (eKIS). This discussion could be done by a non-clinical person in the team, with the supporting guidance for these discussions shared in Annex C of the letter. Information on how to enter data in KIS was also included Annex D.

This letter to practices also stated:

**In addition for some patients in this group it may be appropriate to discuss their Anticipatory Care Plan. This discussion should be done by a clinician but again it doesn't have to be a GP.**

In fact, for many of the patients in the very high risk group it would be more appropriate for them to have their ACP conversation with their treating consultant, who may be in better position to discuss appropriate treatment options based on the patient's individual circumstances.

We are now writing to you with some further information to support the completion of Anticipatory Care plans, and Key Information Summaries, for those patients where the practice and wider multi-disciplinary team feel it is clinically appropriate.

Attached you will find a revised and simplified [Anticipatory Care Template \(Annex A\) which has been developed by Healthcare Scotland](#) (HIS). This template takes into account the guidance previous provided in Annex C of the CMO letter, to try and avoid duplication of more general information gathering and has been designed to capture essential information which should be copied into eKIS.

We would like to take this opportunity to reiterate some key points about completing an ACP. There are four main principles which should be considered:

- a) How we identify people from practice lists, MDT and secondary care caseloads.
  - b) Encouraging all clinical staff to consider and have ACP conversations with patients (this could be face to face, telephone or NHS Near Me consultation).
  - c) Documenting these conversations on the new Essential ACP template or directly onto eKIS as appropriate, depending who in the team is having the discussion with the patient.
  - d) Ensuring the information is shared in a way that it can get onto eKIS.
1. GP Practices and members of the wider MDT such as Community Nurses, AHPs, Carers, Community Mental Health, Learning Disability services, Care Home and Secondary Care clinical staff should use their clinical judgement to decide who on their practice list or caseloads should be a priority for having an ACP conversation and completing an ACP. Many of these patients will already have an ACP, and the team should consider whether it needs to be reviewed and updated.

Where patients are identified on the case-loads (MDT and secondary care) it will be important to have a co-ordinated approach to care planning, with communication between the different teams, a priority to avoid the risk of duplication of effort.

2. That ACP conversation and completion of the form does not always need to be completed by a GP and can be completed by other members of the clinical team eg General Practice Nurse, District Nurses, AHP, Speciality Community Nurses, Care Home staff, Hospital clinician etc.

When an ACP is completed by a member of the wider Health and Social Care team or a Hospital Clinician a copy should be kept with the patient where possible and a copy sent to the GP practice. When completed by a member of the practice team

who has access to the practice clinical system following discussion with the patient it may be entered directly into eKIS.

3. Where the ACP has been completed by somebody out with the practice team, the GP practice could provide support by copying the information into the eKIS. There are a number of ways this could be done, such as allowing external clinical staff to have access to the practices clinical system, or for an administrative person in the practice to enter the information into eKIS where practice workload and capacity allow. The process for passing completed ACPs to the appropriate practice should be agreed locally eg a generic email address,
4. We recognise that DNACPR discussions are always difficult ones to have, even more so when being done over the telephone. It is also recognised that CPR has a very low chance of success when cardiopulmonary arrest is in the context of severe Covid illness. Therefore we would like to reassure clinicians that there is no specific requirement to have a DNACPR discussion as part of this ACP conversation, unless the patient raises this and wishes to discuss it, or the clinician feels strongly that they need to discuss it. Instead the focus should be on supportive discussions with patients about what matters to them should they fall ill with Covid. The HIS ACP template provides a framework for your discussions, with the option to complete the DNACPR section, if this is discussed. Guidance on having difficult conversations has been developed and is attached in Annex B.
5. We also recognise the importance for both patients and clinicians of ensuring supportive and high-level public messaging around the benefit of anticipatory care planning conversations. This is being developed as a matter of urgency within the Scottish Government to accompany this work. Patient resources are also being developed to help facilitate their conversations with carers and families, and these will be available in the coming days on [www.nhsinform.co.uk](http://www.nhsinform.co.uk) .

We realise this is challenging work and we intend to support this with clear, high-level public messaging around its importance. We're working to have revised Covid-19 related Anticipatory Care Planning information on NHS Inform by the end of this week.

Please also note the publication on 3 April 2020 of the [Covid-19 Ethical Advice and Support Framework](#) and [Clinical Advice](#). The CMO published these documents on 3 April 2020. They are intended to support clinicians with decision making during this pandemic.

As stated by the CMO please accept our sincere thanks for your support, patience and courage during this challenging time. We realise that workload and capacity in General Practice just now is challenging, but we also understand that you put the best interest of your patients to the forefront.

Further resources and information about anticipatory care planning are on [Healthcare Improvement Scotland's website](#).

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Gregor Smith', with a stylized flourish at the end.

Dr Gregor Smith  
Interim Chief Medical Officer

A handwritten signature in black ink, appearing to read 'Andrew Buist', with a large, stylized initial 'A'.

Andrew Buist  
Chair of the Scottish General Practitioners  
Committee of the BMA

A handwritten signature in black ink, appearing to read 'Carey Lunan', with a large, stylized initial 'C'.

Carey Lunan  
Chair of the Royal College of General  
Practitioners

## Having significant conversations to support those most vulnerable to coronavirus

There are particular groups of individuals who are at [increased risk](#) of severe illness from coronavirus. These people would benefit from having a 'Key Information Summary' created or updated. Many will also benefit from Anticipatory Care Planning.

There is a second group of people who are at [much higher risk](#) of becoming seriously unwell from coronavirus, and are already at greater risk of dying from infections and other health problems. This group should be prioritised for Anticipatory Care Planning. This template can be used to document these discussions and shared on the Key Information Summary.

This is an important opportunity for people to have conversations with carers and loved ones about the type of care that they would like to receive should they become unwell.

We know that treatments for coronavirus focus on supportive measures, and specific care options like ventilation are of low benefit or do not help people who are already in poor health. However, there are many other aspects of care that can be discussed and planned. People may well be worried about the future, and so there is an opportunity to have a helpful conversation about what matters to them if they become very unwell and die.

These discussions can be extremely difficult to start, but they are important and helpful. The aim is to have an open and honest conversation with people and their families and carers so that we can plan future care as well as possible.

The [RED-MAP framework](#) can be helpful to guide discussions about ACP

<https://www.ec4h.org.uk/covid-19-effective-communication-for-professionals/>

<b>R</b> eady:	Can we talk about how coronavirus might affect you?
<b>E</b> xpect:	What do you know? What do you want to ask?
<b>D</b> iagnosis:	We know that coronavirus.... We don't know.....
<b>M</b> atters:	What matters to you if you were to become unwell?
<b>A</b> ctions:	What we can do to help is....
<b>P</b> lan:	Let's plan ahead for 'just in case'

Depending on how the conversation goes, you may consider exploring other relevant aspects of [Anticipatory Care Planning](#). Some people may not be ready for this conversation and it may be necessary to revisit it at another time. Focus on the benefits of having a plan for each person and, if possible, offer another opportunity with you or a colleague.

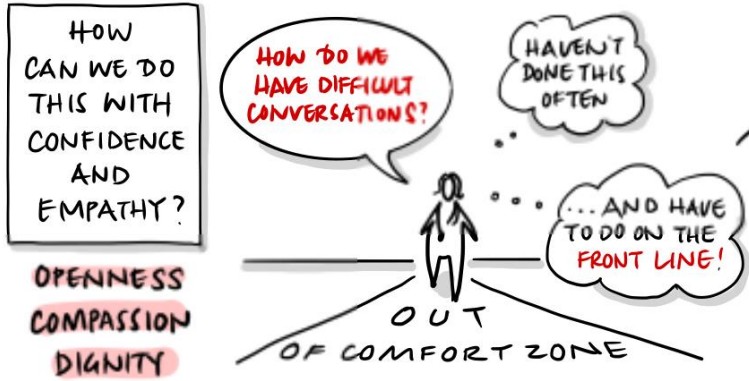
## An essential ACP for those most vulnerable to coronavirus

<b>Name</b>		<b>Preferred name</b>	
<b>CHI or DoB</b>		<b>Phone number</b>	
<b>Address</b>			
<p>Ask: 'If you were to become seriously unwell due to an infection such as the coronavirus, how would you like to be cared for?</p> <p>Ask: 'Is there anyone that you would like to be involved in future decisions about your care, if you were to become unwell (e.g. a friend, family member or carer)?</p> <p>Note: Specific care options e.g. ventilation in intensive care may not be available or appropriate. It may help to explore this further and consider whether comfort options such as symptom control would be a priority.</p>			
<b>The things you would like:</b>			
<b>The things you do not want:</b>			
<b>Any other information around preferences for care:</b>			
<b>Discussions about cardiopulmonary resuscitation:</b>			
<p>Is this person to have cardiopulmonary resuscitation? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If NO, Is a DNACPR form completed? YES <input type="checkbox"/> NO <input type="checkbox"/></p>			
<b>The people you would like to be involved in decisions about your care. (List names and contact info.)</b>			
<p>Do any of these people have <a href="#">power of attorney</a> or welfare guardianship? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If so, what are their names?</p>			
<b>Other important contacts (next of kin / carer / neighbour):</b>			
<b>Key worker (social / health care worker/ mental health support/ others )</b>			
<b>Name and contact details of Responsible Clinician (Consultant/ GP/ Other)</b>			
<b>Name and designation of person who has led this ACP discussion</b>			<b>Date completed:</b>
<p><b>Consent obtained to share in Key Information Summary (good practice but not mandatory)</b></p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Please send this completed electronic word document to the GP practice so that the above information can be copied and pasted into the special notes section of the Key Information Summary</p>			



① WE WILL HAVE TO TALK ABOUT DYING: COVID-19

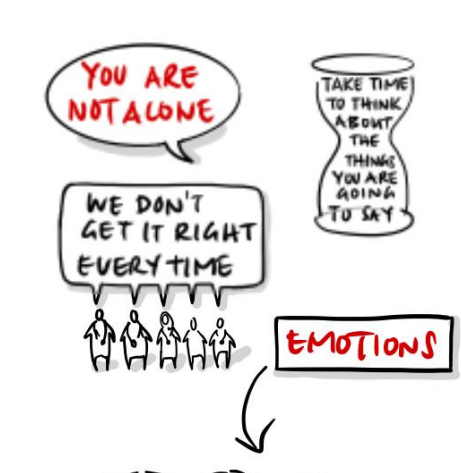
ALL CLINICIANS, SOME WORKING OUTSIDE USUAL AREA



② WHY IS THIS SO HARD?



③ SUPPORT + PREPARATION



⑤ THINGS YOU MIGHT SAY...



④ REDMAP FRAMEWORK

- R** EADY - CAN WE TALK ABOUT YOUR CARE?
- E** XPECT - WHAT DO YOU KNOW/WANT TO ASK?
- D** IAGNOSIS - WE KNOW/DON'T KNOW
- M** ATTERS - WHAT MATTERS TO YOU?
- A** CTION - THIS CAN HELP/THIS WILL NOT HELP
- P** LAN - LET'S PLAN GOOD CARE FOR YOU + YOUR FAMILY

