Future care planning

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ABSTRACT

Future care planning (FCP) is increasingly discussed within supportive and palliative care policy contexts in the UK and internationally. This article incorporates a scoping review of the literature to provide a summary overview. FCP is discussed as a policy element improving end-of-life care by encompassing advance care planning and furthermore including individuals with diminished decision-making capacity through a best-interests approach. The evidence base further indicates that FCP is being increasingly applied in palliative care settings worldwide and has been adopted as part of several national strategies, including in Wales and in Scotland. A clear and consistent definition of FCP will help support health and social care professionals working in frailty and palliative care. Our review identified definitions of FCP in the existing literature and described what a future care plan is, including what end-of-life care should look like and incorporate.

BACKGROUND

Advance care planning (ACP) has been defined by the National Institute for Health and Care Excellence as 'a voluntary process of discussion about future care between an individual and their care providers, irrespective of discipline'.[1]

However, ACP requires decisional capacity. Therefore, due to its core definition potentially excluding patients who lack mental capacity regarding specific care decisions and situations, due to cognitive impairments or chronic illness.

Future care planning (FCP) has emerged as an inclusive approach. It seeks to proactively address any limitations of traditional ACP, by integrating a best-interests model aligned with international ethical and legal standards.[2]

METHODS

A search was conducted across a wide-ranging set of databases: Ovid Medline, Ovid Embase, Scopus and Web of Science Core Collection from January 1999 to 5 July 2024. Reference lists of systematic reviews were checked, and websites searched for relevant publications. Study selection was carried out by two independent reviewers. The full text was then assessed independently using a predesigned eligibility form according to inclusion criteria. Data were extracted by one reviewer and checked for accuracy by a

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ One of the core activities of future care planning (FCP) is the traditionally understood advance care planning or anticipatory care planning ethos; but importantly, FCP proactively includes and incorporates patients with diminished capacity at the time of information gathering, for whom a best interest approach should be followed.

WHAT THIS STUDY ADDS

⇒ This scoping review provides a much-needed assessment of the term 'FCP' as it is used in the research literature, thereby supporting health and social care professionals and policy-makers in practice.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ The clarified definition and structured scoping review approach provided by this review provides a baseline definition to enhance clinical practice consistency, inform future research priorities and shape effective healthcare policies in end-of-life care.

⇒ FCP is increasingly prevalent in palliative and supportive care strategies internationally, notably in NHS Wales and NHS Scotland. Recognising the complexity of providing end-of-life care, healthcare systems globally are adopting broader terminology and structured processes to enhance patient-centred outcomes. This review of current practice explores existing definitions and describes essential components of FCP, with a particular focus on frailty and patients with diminished decision-making capacity, thereby facilitating comprehensive patient-centred planning.

second reviewer. Figure 1 represents the flow of information through the different phases of the review.

RESULTS

199 articles were identified, of which 167 articles met the inclusion criteria. 77 full-text articles were screened, and 21 articles were included in the final review. Within this literature, multiple terms were used to describe components of FCP, ranging from ACP and Health Care Directives to Treatment Escalation Plans (see box 1). Different terms were used to describe the umbrella phrase FCP, and these included, for example, ACP, Advance Care Directives (ACD), State Administration Tribunal, Enduring Power of Attorney, Enduring Power of Guardianship. The adoption of FCP in healthcare policy in the UK, particularly by Nationl Health Service (NHS) Wales and NHS Scotland, underscores its increasing recognition as an approach to address end-of-life complexities. Patient and caregiver advocacy groups in Wales notably influenced the adoption of the term 'future care planning,' suggesting it was more comprehensible than traditional terminologies such as ACP.[3]

Common components of FCP identified across literature included structured dialogues between patients, families and healthcare professionals, emphasising patient preferences and values to provide a high standard of person-centred care.[4]

Additionally, consistent recording and shared documentation of patient preferences across healthcare teams have been highlighted as essential through both professional experience and across the literature.[5] Digital recording should become standard. But it can be seen more widely, with new digital formats of discussing and conversing future care plans, such as video consultations becoming the norm.[6 7] Within ACP, well documented and easily accessible information has been shown to demonstrate a significant reduction in rates and cost of hospital admission across care settings.[8–10]

Within the clinical setting, legally recognised documentation such as Lasting Power of Attorney and Advance Decisions to Refuse Treatment are often discussed with families and relatives. When reviewed within the literature, these legal frameworks are discussed as commonly useful but not always universally applicable, particularly in those with diminished capacity.[11]

Specific focus on the inclusion of vulnerable populations with cognitive impairments within FCP is stressed, aligning with current legal frameworks such as the Mental Capacity Act (2005) in the UK.[12 13]

DISCUSSION

FCP emerges as an umbrella framework, bridging the gap between traditional ACP and the more intricate needs of patients with diminished capacity. Unlike ACP, FCP explicitly integrates best-interest decision-making processes into legal frameworks, reflecting broader societal shifts towards inclusivity and proactive healthcare planning.

Clarifying FCP's scope and components has implications not only for clinical practice but also for shaping robust health policies and resource allocation within healthcare systems. In the included literature, the following characteristics of FCP are described as follows: FCP is an opportunity for individuals to work with health and social care professionals to consider what matters most to them nearer the end-of-life, in terms of their well-being, and to explore their wishes for any future care or support that the person may need. FCP can be relevant to every stage of life, including those with diminished capacity at the time of information gathering and for whom a best interests approach should be followed. FCP discussions and dialogue should be recorded (including electronic patient records) and should be shared with those close to the person, caregivers and professionals involved in care. Such a plan may include the individual preferences about the nature, type and location of such services and may include discussions relating to the individual's medical treatment and wishes for end-of-life care. Given the global demographic shifts towards ageing populations and increased prevalence of chronic illness and frailty, standardised implementation of FCP can significantly enhance patient-centred outcomes and satisfaction.[14 15]

Moreover, recent findings indicate the potential of structured FCP processes to reduce healthcare resource utilisation at end-of-life, enhancing communication, reducing distress among caregivers and potentially lowering overall healthcare costs through improved management of end-of-life decisions.[4]

SUMMARY

Clarity and consistency in the definition and implementation of FCP is essential to ensure its integration into healthcare policy. Current literature suggests a standardised definition of FCP could be as follows.

> *Future Care Planning (FCP) is an opportunity for an individual to work with health and social care professionals to consider what matters to them in terms of their wellbeing and explore their wishes for any future care or support that the person may need, in the context of their condition, circumstances and options. FCP is relevant to every stage of life, including for those who may have diminished capacity at the time of information gathering, and for whom a best interests approach should be followed. The discussions and decisions are recorded and should be shared with care givers, families and professionals involved in their care. The output from FCP conversations may include a plan or other document reflecting the person's preferences about*

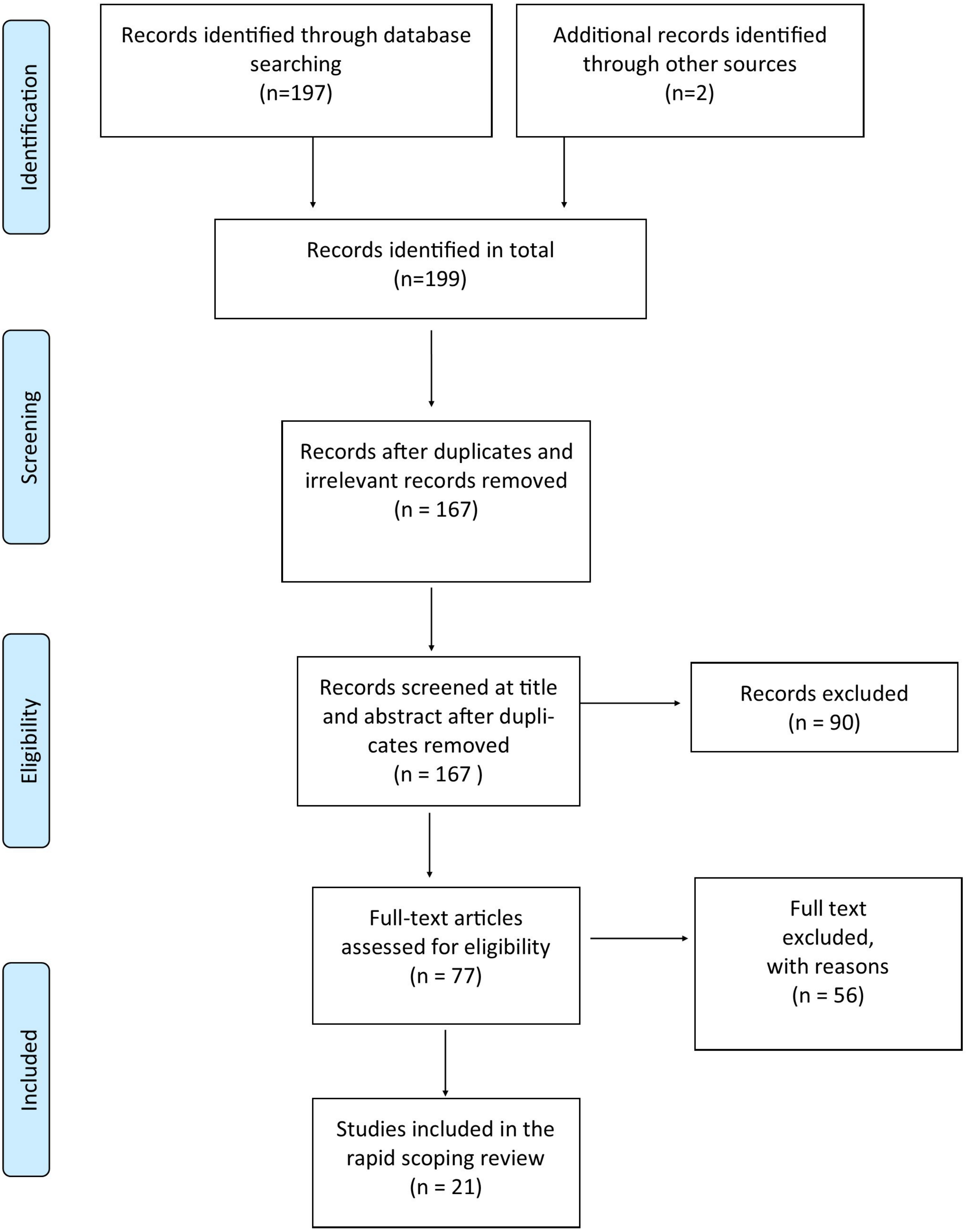

Figure 1 represents the flow of information through the different phases of the review.

Figure 1 Flow of information through the different phases of the review.

Box 1 Terms used to describe components of future care planning

⇒ Advance Care Directive (ACD)
⇒ Advance Care Planning (ACP)
⇒ Advance Decision to Refuse Treatment (ADRT)
⇒ Advance Decision (AD)
⇒ synonymous with ADRT
⇒ Advance Statement (AS)
⇒ Decision Aid (DA)
⇒ Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)
⇒ Enduring Power of Attorney (EPA)
⇒ Enduring Power of Guardianship (EPG)
⇒ Future Care Plan (FCP)
⇒ Goals of Care Document (GCD)
⇒ Health Care Directive (HCD)
⇒ Inpatient Treatment Escalation Plan
⇒ Lasting power of attorney (LPA) for health and well-being
⇒ Personalised Advisory CarE or (Proactive Elderly Advance CarE) (PEACE) plan
⇒ Plan Program (PAP)
⇒ Record of Best Interests Decision (RBID)
⇒ Shared Decision Making (SDM)
⇒ State Administration Tribunal (SAT)
⇒ Treatment Escalation Plan (TEP)

> *the nature, type and location of such services and may include discussions in relation to a person's medical treatment and views on how their end of life care might look. Such output does not contain legally binding decisions, but rather helps guide decisions about treatment and care in the context of realistic appraisal of what is possible in the relevant circumstances. It can contribute to achieving a 'no decision about me, without me' approach in all eventualities including when circumstances change, or when the person, or those close to them, express the need for a review.*

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