



Future Care Planning
Greater Glasgow & Clyde
Guidance/Standard Operating Procedure
Updated Aug 2025

Lead(s):	Kim Campbell, HSCP Unscheduled Care Change & Improvement Manager Jennifer Watt, HomeFirst Design & Implementation Manager
Developed by:	HomeFirst Programme
Responsible Director:	Fiona Smith
Approved by:	Quality Oversight Strategy Group
Date approved:	
Date for Review:	Aug 2028
Replaces:	Anticipatory Care Planning GGC SOP (July 2022)
Replaces previous version: [if applicable]	

Contents

1. Purpose of this Document.....	5
2. Introduction	5
3. Scope (including target population)	6
3.1. Target Population for Future Care Planning.....	6
3.2. Are Future Care Plans appropriate if someone lacks capacity?	6
4. Roles and Responsibilities.....	7
4.1. All Employees	7
4.2. Team Leads	7
4.3. Service Managers	7
4.4. Future Care Planning Champions	8
4.5. HSCP Unscheduled Care Leads/Anchors	8
4.6. Other Professionals Working Alongside NHSGGC	9
5. Public Communication & Information	9
6. Having Future Care Planning Conversations	10
6.1. Initiating the Future Care Planning Conversation.....	10
6.1.1. Tools to Help Structure Future Care Planning Conversations	11
6.1.2. Documenting when someone does not wish to have a Future Care Plan	11
7. Content of Future Care Planning Conversation	12
7.1. Key topics	12
7.1.1. DISCUSS.....	12
7.1.1.1. D – Decisions	12
7.1.1.2. I – Interventions	13
7.1.1.3. S – Social Relationships	13
7.1.1.4. C – Cardiopulmonary Resuscitation (CPR)	13
7.1.1.5. U – Understanding You	13
7.1.1.6. S – Surroundings	13
7.1.1.7. S – Services	14
7.1.2. Frailty	14
7.1.2.1. Further Guidance on Rockwood Frailty Assessment	15
7.1.3. Treatment Escalation Plans	15
7.2. Consent.....	16
7.2.1. Sharing Information with Other Professionals	16
7.2.2. Sharing Information with a person’s family/friends/carers	17
7.2.3. Discussions where capacity is in question	17

7.2.3.1. Recording Power of Attorney/Guardian Details.....	18
7.3. Managing Expectations	18
7.4. Paperwork.....	18
7.4.1. Clinical Portal.....	19
7.4.1.1. How to set up an account	19
7.4.1.2. Viewing and Updating the Future Care Plan Summary on Clinical Portal	20
7.4.1.3. Changing to New Format of Future Care Plan Summary	21
7.4.2. Information recorded in the Future Care Plan Summary	22
7.4.2.1. Staff Details	22
7.4.2.2. Trigger for Future Care Planning	22
7.4.2.3. Identifying Author of Open Text Notes	22
7.4.2.4. Deletion of Previous Information	22
7.4.2.5. Saving Future Care Plan Summary on Clinical Portal.....	23
7.4.2.6. Adding Information to a Previous Summary.....	23
7.4.3. Transfer to Key Information Summary	23
7.4.3.1. Why does information need to be stored on both systems?.....	23
7.4.4. Key Tasks	24
7.4.4.1. Primary Care	24
7.4.4.2. Onward Referrals Including DNAPCR	25
7.4.4.2.1. Who to refer to for further DNACPR discussions?	26
7.4.4.2.2. Other Referrals	26
8. Recording the Future Care Planning Journey	26
8.1. Collection of Data for Local Reporting.....	27
8.1.1. EMIS	27
8.1.2. CNIS	27
8.2. What Steps Are Recorded?	29
8.2.1. EMIS	29
8.2.2. CNIS	30
8.3. Responsibility	30
8.3.1. HSCP Leads	30
8.3.2. Identified Local Leads (i.e. Team Leads, Service Managers etc.)	31
9. Review.....	31
9.1. When to Review	31
9.2. Responsibility	31
10. Future Care Plans in Care Homes.....	31
10.1. Clinical Portal	32
10.2. PDF Summary	32
10.3. LES v non LES Care Homes.....	32
10.4. Care Home Liaison Nurse (CHLN) Role	32
10.5. Care Home Collaborative	33
10.6. Future Care Planning Champions in Care Homes	33

10.7. The 3 Question Project in Care Homes	34
10.8. Training for Care Home Staff (see also Section 12)	34
10.9. Good Practice Example for Care Homes	35
11. Future Care Planning in Children's Services.....	35
11.1. Future Care Planning documentation used in Children's Services.....	35
11.1.1. Creation of a Future Care Plan in Children's Services	36
11.1.2. Conversations regarding resuscitation and CYPADM	36
11.1.3. Sharing Information Across Children's Services	36
11.2. Future Care Planning for Antenatal Services	37
11.3. Transitioning to Adult Services	37
12. Training	37
12.1. E-Learning	37
12.2. Bite-Sized Learning.....	38
12.2.1. Introduction to Future Care Planning	38
12.2.2. Clinical Portal Walkthrough	38
12.2.3. Rockwood Clinical Frailty Scale Overview	38
12.2.4. Power of Attorney Overview	39
12.2.5. CNIS Codes	39
12.2.6. EMIS Codes	39
12.3. Other Training Opportunities	39
12.3.1. For All Staff	39
12.3.2. Registered Professionals Working in Care Homes	40
12.4. Other educational resources	40
13. Quality Assurance.....	40
13.1. Quality Assurance Tools	40
13.2. Example Future Care Planning Summaries	41
14. Supporting Guidance.....	41
14.1. Hyperlink index	41
14.1.1. Future Care Planning Documents and Guidance	41
14.1.2. Future Care Plan Summary Examples	42
14.1.3. Further Topic Specific Information	43
14.1.4. Professional Guidance	43
14.1.5. Training Links	43
14.1.6. Website Links.....	44
15. Annex	45
15.1. Process Flowchart	45
15.2. Updates to Previous SOP Versions.....	46
15.2.1. Update – July 2022	46
15.2.2. Update – Aug 2025.....	46

1. Purpose of this Document

Across GGC there is a wide range of individuals developing Future Care Planning; ensuring consistent quality is a significant challenge.

This document has been developed to provide guidance and to standardise many key tasks and processes to maximise the opportunities to discuss what is important to an individual regarding their future care and to ensure this information is recorded to allow those involved in providing health and social care in future to access this information

The document also contains quick links to a number of key resources and reference documents.

2. Introduction

Future Care Planning (previously “Anticipatory Care Planning” or “ACP”) is a person-centred, proactive approach to help people to plan ahead and to be more in control and able to manage any changes in their health and wellbeing.

At the heart of Future Care Planning is a conversation between individuals, those people who are important to them, for example a relative or carer, and their health or social care professional.

These conversations will support choices or decisions about future care and can include:

- reflections on an individual’s situation and priorities in the context of their health
- information about specific treatments or care that would be appropriate for an individual, when they would consider or accept this care, and where they would like to be cared for, and
- information on who should be involved in supporting future decisions about treatment and care.

Future Care Planning is particularly beneficial for those who have a long term health condition, or for those who are noticing or anticipating a change in their health, as it can help them to make informed choices about their future care.

These choices and decisions should be documented in a Future Care Plan and shared with the people that need to know.

3. Scope (including target population)

3.1. Target Population for Future Care Planning

Future Care Plans are particularly beneficial for those who have a long term health condition, or for those who are noticing or anticipating a change in their health, as it can help them to make informed choices about their future care.

Particular effort should be given to ensuring that all people in Greater Glasgow and Clyde over 65 with a chronic condition and are at high risk of admission to hospital are given the opportunity to discuss and record their wishes and preferences as part of a Future Care Planning conversation.

Age should not be a limiting factor when considering whether someone could benefit from a Future Care Plan. Therefore consideration should also be given to people who

- Are on palliative pathways
- Are care home residents
- Are frail
- Live in residential care (including nursing or care homes)
- Have a neurological decline
- Have frequent hospital admissions
- Have needs identified using deterioration tools (e.g. SPICT or SPAR)
- Have a long term condition
- Have a high dependency on services
- Have an informal carer

3.2. Are Future Care Plans appropriate if someone lacks capacity?

If someone lacks capacity, this does not automatically exclude them from having a Future Care Planning. There may be some topics of conversations that will not be appropriate to have as they require someone to have capacity (e.g. some treatment options, Power of Attorney discussions, DNACPR). However it can still be useful to document what matters to the person and things that could be put in place to provide appropriate person-centred care (e.g. allowing someone to be in a quiet space where possible if loud noises make them agitated, or noting a particular activity that can calm them down when anxious).

Some services may already have documentation that helps record this information such as “Getting to Know Me documents” or “Life Plans”, however it is helpful for this information to be recorded in the Future Care Plan Summary Document so that it can be shared across multiple services.

If someone, who currently lacks capacity, has a Power of Attorney or Guardian they must be included in Future Care Planning conversations. The details of the Attorney/Guardian should also be recorded on the Future Care Plan Summary

documentation, including when the valid documentation was verified by a professional.

If capacity is in question please document this in the “special notes” section of the Future Care Plan Summary so that all professionals are aware of the situation and can respond accordingly.

The Scottish Government have produced [guidance for professionals who need to assess capacity](#).

4. Roles and Responsibilities

This procedure applies to all Acute and Health & Social Care (Adult) service employees. See [Section 11](#) for use of Future Care Planning in Children’s Services.

For other professionals including those working in Care Homes, hospices and third sector partners please see [Section 4.6](#).

4.1. All Employees

It is the responsibility of all staff involved with an individual’s assessment to start the conversation about the benefits of Future Care Planning and to carry out the Future Care Planning conversation, if agreed, and to ensure the detail of conversation is recorded as per this procedure.

4.2. Team Leads

It is the responsibility of Team Leads to encourage and support their respective team members to maximise the opportunities to engage with individuals and their family members/carers about Future Care Plans.

- To support this Team Leads are advised to:
- Add Future Care Planning to team meeting agendas
- Share the number of Future Care Plans recorded on Clinical Portal
- Monitor progress against local HSCP targets
- Share examples of good practice
- Encourage all team members to complete relevant training (see [Section 12](#))

4.3. Service Managers

It is the role of Service Managers to monitor Future Care Planning activity across all of their areas of responsibility and to report this through their locally agreed

governance groups re progress and to highlight areas needing improvement, support or where risk is identified.

4.4. Future Care Planning Champions

A [Future Care Planning Champion](#) works with their colleagues to help promote the use of Future Care Plans, offering advice and information to help empower staff to have these conversations with the people they work with. They will help promote a positive Future Care Planning culture across NHSGGC, working together to give people control over their lives.

Future Care Planning Champions are not solely responsible for their team completing Future Care Plans. The role will depend on conversations with Line Managers and the needs of the team however could include:

- Helping to create a positive Future Care Planning culture across the entirety of the NHSGGC Board Area
- Promote the use of Future Care Plans within the work of the team
- Support members of the team to complete Future Care Plans by offering advice and information on best practice including training new team member on how to use and record Future Care Plans
- Provide feedback to the local implementation groups on behalf of colleagues
- Distribute communication regarding Future Care Planning to colleagues
- Assist Team Lead to update and track recording statistics
- Collaborate with colleagues across NHSGGC and HSCP's to share best practice
- Stay up to date with all Future Care Planning developments and share these with colleagues

Champions are recruited and supported through local arrangements and there is no longer a central formal registration process. Please speak to your Line Manager if you are interested in this role.

4.5. HSCP Unscheduled Care Leads/Anchors

It is the role of HSCP UCC Leads/Anchors to monitor and report on local performance against their respective Future Care Planning plans. This should be shared at their HSCP Unscheduled Care Groups.

The Anchor should raise any incidents that occur requiring attention, examples of good practice and provide performance updates.

4.6. Other Professionals Working Alongside NHSGGC

NHSGGC working in partnership with many other organisations to provide care and support the wellbeing of the population. This includes Hospice Teams, independent Care Homes and numerous third sector partners such as Macmillan and Alzheimer's Scotland.

Where organisations have Service Level Agreements (SLAs) with NHSGGC, permission may be given to access NHSGGC internal systems including Clinical Portal. This will result in staff being able to access the Future Care Plan on the system. In most cases staff will have permission to read and write onto this form.

If staff have been granted access to the Clinical Portal system then they have the same responsibilities as all other NHSGGC employees in terms of having Future Care Planning conversations and recording information (see [Section 4.1](#))

Please note that it is not currently possible to give independent Care Homes access to NHSGGC systems, therefore staff will not have access to Clinical Portal. As these homes are independent organisations they may choose to use their own paperwork to record Future Care Planning information, however we would ask management consider using the [interactive PDF summary](#) to provide consistency across NHSGGC and ensure all relevant information is recorded. See [Section 10](#) for further information relating to Care Homes.

5. Public Communication & Information

It is important that we communicate to the public the benefits of planning ahead and encourage them to begin the process of having Future Care Planning conversations. We need to acknowledge that many of these conversations cover sensitive topics and therefore ensure these are discussed at an appropriate time and in an appropriate environment.

In order to prepare people for these discussions it is good practice for staff to give an overview of the types of topics that could be discussed and offer further information for people to review before conducting fuller Future Care Planning conversations. Guides for the public have been created which outline the DISCUSS topics (see [Section 7.1.1](#)).

The public can also be directed to the [NHSGGC Future Care Planning webpages](#) for further information covering topics such as:

- [Future Care Planning](#)
- [Cardiopulmonary Resuscitation \(CPR\)](#)
- [Planning for Unexpected Events](#)
- [Hospital Discharge](#)
- [Power of Attorney](#)

- [Carer Support](#) (including [Carer Support Plans](#))
- [Wills](#)
- [Supporting Someone Who is Dying](#)
- [What To Do When Someone Dies](#) (including [Funeral Planning](#))
- [Bereavement Support](#)
- [Organ and Tissue Donation](#)
- [Emotional Support](#)

There is also information about [different websites and organisations](#) that can provide support and information to the public on a range of topics.

6. Having Future Care Planning Conversations

6.1. Initiating the Future Care Planning Conversation

Good communication is the key to success. Some people will not have considered these topics before. It is important that you give them time and space to reflect before having these conversations.

In order to prepare people for these discussions it is good practice for staff to give an overview of the types of topics that could be discussed and offer further information for people to review before conducting fuller Future Care Planning conversations. [Guides for the public](#) have been created which outline the DISCUSS topics (see [Section 7.1.1](#)).

These discussions are really important; however we understand that some staff members might not always feel comfortable having them. Try not to overcomplicate the matter – we can start conversations with a simple question like ‘what matters to you?’ or ‘how would you feel if you have to go to hospital?’ and we often find that people are keen to discuss this, as are those who matter to them.

You may also feel like you don’t know enough about some topics to give advice to others. For example you might not feel able to answer some questions about DNRCPR, or you might be unsure of the level of support home care can give. If someone asks a question that you don’t know the answer to, be honest about this. Tell them you are not sure right now but you will find the information and get back to them. Talk to your colleagues to try and find out the necessary information.

6.1.1. Tools to Help Structure Future Care Planning Conversations

There are lots of different models and frameworks that can help structure a conversations such as [RED-MAP](#) or [Sage & Thyme](#). These are tools to help people navigate difficult conversations by breaking them down in to smaller manageable chunks. The NHSGGC Palliative Care Team provide specific training for both of these communication frameworks for all health and social care professionals (see [Section 12](#)).

Talking about Care Planning with REDMAP	
Ready	Can we talk about your health and care? Who should be involved?
Expect	What do you know ? Do you want to tell/ask me about anything? What has changed? Some people think about what might happen if...
Diagnosis	What we know is... We don't know ... We are not sure ... I hope that, but I am worried about... It is possible that you might.... Do you have questions or worries we can talk about?
Matters	What is important to you and your family? What would you like to be able to do ? How would you like to be cared for? Is there anything you do not want ? What would (<i>name</i>) say about this situation, if we could ask them?
Actions	What we can do is... Options that can help are.... This will not help because.... That does not work when...
Plan	Let's plan ahead for when/if.... Making some plans in advance helps people get better care.

Figure 1. RED-MAP Framework developed by Dr Kirsty Boyd, Macmillan Reader in Palliative Care.

6.1.2. Documenting when someone does not wish to have a Future Care Plan

If a person (or their legal proxy) does not wish for Future Care Planning information to be shared across services, they can refuse and opt out of having a Future Care Plan contained within their files. This should be documented in the Future Care Plan Summary using the question provided. The reason for their refusal should also be documented in the summary, alongside any information regarding whether or not the conversation could be revisited.

<p>Following initial conversation would individual (or their legal guardian) like to share information via Future Care Plan? *</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="button" value="x"/></p> <p><i>If declined, please provide detail including reason for refusal and if/when conversation could be revisited.</i></p>
--	---

Figure 2. Question in Future Care Plan Summary to document if someone wishes to have a Future Care Plan.

Where possible, it is good practice for staff to revisit this conversation at a later date in case opinion changes. It can also be beneficial to clarify if there is any level of detail that could be shared e.g. Power of Attorney information, Carer information, health goals etc. It should be noted that this information is likely to exist within other system notes which may already be being shared across multiple services.

7. Content of Future Care Planning Conversation

7.1. Key topics

Future Care Planning conversations can cover a range of different topics. It may be inappropriate to discuss some of these topics at particular times (e.g. talking to someone about DNACPR following a new non-terminal diagnosis). There may be some topic discussions that never take place depending on timelines and/or the person's willingness to engage.

7.1.1. DISCUSS

Using the word "Discuss" as a guide, a short list of possible Future Care Planning topics has been created.

7.1.1.1. D – Decisions

We should talk to people and those that matter to them to check they understand everything that we are talking about. We may need to provide additional information or change the way we communicate to help them understand. We also need to think about capacity (See Section [7.2](#) and [7.3](#)) and involve any Power of Attorney. If they do not have a Power of Attorney we should suggest this and [offer them more information](#).

7.1.1.2. I – Interventions

We should talk to people and those that matter to them about things we could do to help them, as well as things they might not like to happen. We would also talk to them about treatments that we don't think would be good for them. This is a core part of the [shared decision making process](#) which is advocated through [Realistic Medicine](#).

Remember that interventions don't just mean clinical or medical treatments. It may also be useful to have conversations about social interventions, or how they feel about statutory care services coming into their home to support them.

7.1.1.3. S – Social Relationships

We should talk to people and those that matter to them about what kind of informal support, friends, family members or neighbours currently give. We should discuss if there is any additional support these unpaid carers may need and possibly [refer them to Carer Support Service](#). We should involve carers in these conversations, however if the person has capacity then it is up to them to decide what we can share with others. We should ask the person who they want to be involved in these discussion, and if there is anyone who they do not want involved.

7.1.1.4. C – Cardiopulmonary Resuscitation (CPR)

[Cardiopulmonary Resuscitation](#) (CPR) is a process which tries to restart someone's heart. In most cases it will not be successful. We should talk to people and those that matter to them about whether this might be appropriate for them and how they feel about it. While someone has the right to refuse CPR, they do not have the right to demand this course of treatment – this means that someone can ask for a Do Not Attempt Cardiopulmonary Resuscitation form to be completed. Ultimately whether or not CPR is in the best interests of the person is a clinical decision, however these decisions should always be explained to the person and those that matter to them.

7.1.1.5. U – Understanding You

We should talk to people and those that matter to them about what makes them happy and brings comfort. This might be things like religion or faith, but could also involve how they like to spend their time and the "little things" that bring them joy.

7.1.1.6. S – Surroundings

We should talk to people and those that matter to them about where they would like to receive care and treatment. This could be short or long term treatment. We may also need to talk to them about where they would like to receive care towards the

end of their life. This might be at home, hospital, a hospice or a nursing or residential home.

7.1.1.7. S – Services

We should talk to people and those that matter to them about services that may already help them in their day to day life, or other services that could be useful. This might be a clinical service like district nurses, or a social care service like homecare. It could also be support services like Carer Support Services or local community support.

7.1.2. Frailty

One of the main triggers for a Future Care Planning conversations is a decline in an individual's frailty. For more information on triggers for Future Care Planning see [Section 7.5.1.4.2](#).

When completing a Future Care Plan Summary we would encourage all staff to consider carrying out a Rockwood Frailty Assessment and select the appropriate score in the Future Care Plan Summary. Training on the Rockwood Frailty Tool is available – see [Section 12](#) for further information.

If a frailty assessment is not applicable please select “0 – Not Applicable”.

By viewing historic versions of the summary, staff can monitor someone's frailty over time. This information will also give staff an indication of what conversations should be considered to ensure the person has a quality Future Care Plan. (See [Section 13](#)).

7.1.2.1. Further Guidance on Rockwood Frailty Assessment

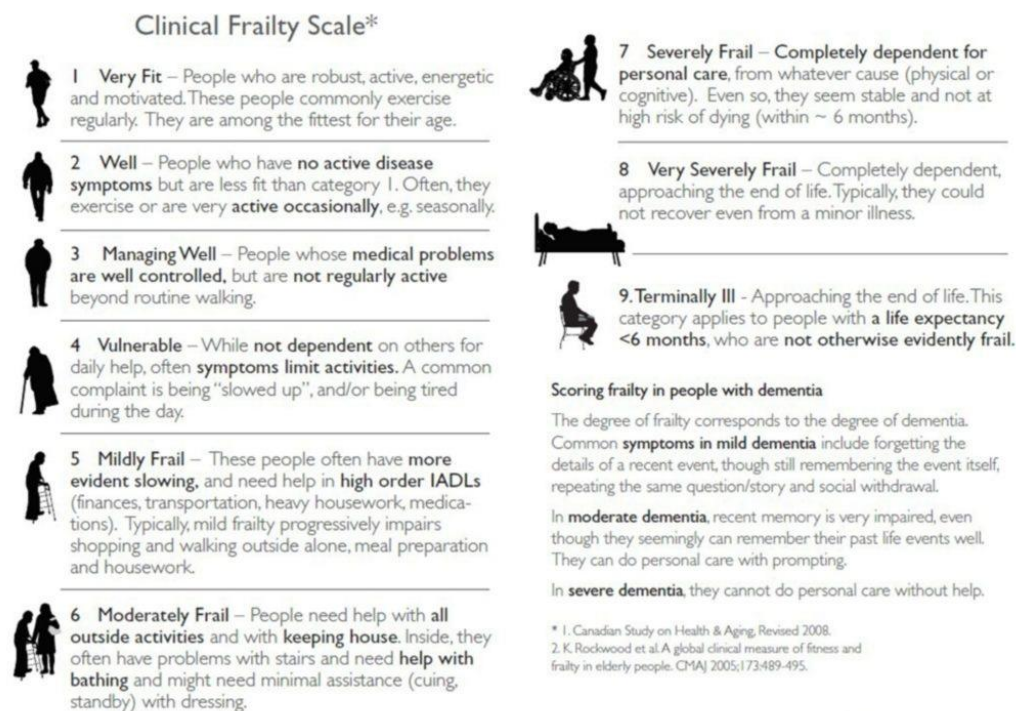


Figure 3. Rockwood Frailty Assessment Chart

Staff can also download an app called Clinical Frailty Scale (CFS) to help with the assessment. This is currently only available for [apple](#).

7.1.3. Treatment Escalation Plans

A Treatment Escalation Plan (TEP) is a document which is completed during a hospital stay (usually on admission or following a change in circumstance). This document records decisions related to escalation of treatment, and the investigations and interventions that are deemed appropriate in the event of deterioration. The aim of this process is to give clear instruction so as to avoid any unnecessary or non-beneficial interventions.

A TEP is only valid until the person is discharged or has died. Upon each new admission a new TEP must be completed.

TEPs should be created as part of a shared decision-making conversation. Therefore having as much information and context about the person and their situation is hugely beneficial. Therefore Acute staff are encouraged to review the Future Care Plan, if available, prior to having TEP conversations with people and those that matter to them.

When a TEP is completed this can be recorded in the Future Care Plan Summary. The date of the TEP, which hospital it was created in, and the level of escalation agreed should all be noted.

Date of TEP Creation *	Hospital of Admission (if known)	Level of Escalation *
16-Dec-2024	QEUH	<input checked="" type="radio"/> Ward Based <input type="radio"/> HDU <input type="radio"/> ICU / ITU

+ Add Row

Figure 4. Treatment Escalation Plan question in the Summary.

Currently the TEP is paper form which remain in the patient record while someone is in hospital. Upon discharge a copy of the TEP will be scanned and uploaded to Clinical Portal, however this may take a while.

By recording that someone has had a TEP in the Future Care Plan, community staff can be alerted to its presence and be prompted to look for the scanned copy. Even if the document is not yet available, by understanding what level of escalation had been agreed whilst in hospital, community staff may have a better understanding of what treatments may be suitable for the person in Acute settings, and therefore be able to manage expectations.

Acute staff should make every effort to update the rest of the Future Care plan with relevant information which has been gained during the admission.

7.2. Consent

7.2.1. Sharing Information with Other Professionals

In June 2020, Scottish Government updated the [Intra NHS Scotland Sharing Accord](#) to reflect the requirement of organisations to share information in order to provide best care for patients. Under this legislation, the sharing of the Future Care Plan Summary information between Health and Social Care professionals is permitted without the need to gain explicit consent from the patient (or their legal proxy). This policy covers information sharing across a range of stakeholders including but not limited to, all Health Boards, Special Boards (including NHS 24 and Scottish Ambulance Services) and Primary Care.

Using this legislation, explicit consent to share Future Care Planning information with other professionals is no longer required. Therefore, when the Future Care Plan Summary was updated in July 2021, the question regarding consent to share information was removed.

However, it remains good practice to ensure people, and those who support them, understand that information contained within the Future Care Plan Summary will be shared with relevant services. Any explanation of what a Future Care Plan is and why it is beneficial should include that information sharing is an integral part of the process.

For more information regarding how to document when someone does not wish to have a Future Care Plan see [Section 6.2](#).

7.2.2. Sharing Information with a person's family/friends/carers

A person may decide not to give permission for Future Care Planning information to be shared with certain individuals within their personal lives (e.g. family member, friend or carer). If the person has capacity, they are free to make this assertion. This does not impact whether or not someone has a Future Care Plan. A note should be made within the "Special Notes" section to outline what information can and cannot be shared with certain individuals.

7.2.3. Discussions where capacity is in question

If capacity is in question please document this in the "special notes" section of the Future Care Plan Summary so that all professionals are aware of the situation and can respond accordingly.

Some topics of conversation will require the person to have capacity in order to engage. For example, discussions regarding treatment options, Power of Attorney and CPR.

Regardless of someone's capacity they should still be involved in conversations as much as possible. This may include conversations about what is important to the person, what their motivations are and who is important to them.

If a Power of Attorney or Guardianship is in place, staff must ensure to include the Power of Attorney/Guardian in all discussions. For more information see [Section 3.2](#).

The Scottish Government have produced [guidance for professionals who need to assess capacity](#).

There may be some clinical information that the Power of Attorney/Guardian believes would cause undue distress to the person, and therefore request this information not be shared. If this is the case, a note can be made in the "special notes section to alert other staff.

7.2.3.1. Recording Power of Attorney/Guardian Details

If someone has a Power of Attorney (POA) or Guardian it is vital that staff record this information in the legal section of the summary so that colleagues know who they should be engaging with. There is an opportunity to record the type of POA someone has (combined, continuing or wellbeing) as well as if it is currently in use. Please answer all questions.

Staff are encouraged to ask to see a copy of the paperwork to ensure that it is valid and record when this occurs. For more information on Power of Attorney see training opportunities ([Section 12](#)).

In the legal section staff can also record if there is an active “Adults with Incapacity (AWI) Section 47” in place.

If someone has a legal guardian, rather than an appointed attorney similar details can be recorded.

7.3. Managing Expectations

Future Care Plans are not legally binding. Depending on service capabilities and availability, some treatment or care options may not be possible (e.g. telecare or experimental treatments). Similarly, whilst it is helpful to record preferred place of care (and death in some cases), circumstances may make some environments untenable.

All staff have a responsibility to ensure that people’s expectations are sensitively managed. This may involve outlining possible situations which would require a particular course of action. For example, if someone has a hip fracture they will likely require hospitalisation for surgery regardless of preference regarding hospital admission. Similarly if someone cannot safely be cared for in their own home alternative arrangements must be made.

It can be beneficial to discuss these possible scenarios and record people’s thoughts and wishes regarding these, within the Future Care Plan Summary. This will allow for greater flexibility within any treatment or care plan whilst still adhering as close as possible to people’s preferences.

7.4. Paperwork

There are multiple places and documents which gather information which could be useful within a Future Care Plan. Many services will have their own paperwork which is likely to record some of this information.

In order to ensure as many people as possible have access to this information and can update information quickly, NHSGGC, alongside the 6 HSCPs, have agreed a format for a [Future Care Plan Summary Document](#). This document closely relates to

the Key Information Summary (KIS) which is updated by Primary Care and can then be shared with other agencies such as NHS 24, OOH and Scottish Ambulance Service.

Staff are asked to update the Future Care Plan Summary with any information they feel is relevant. This includes information that may be stored within their own service documentation as this is not always accessible to other services. [A guide](#) been created to help staff identify what information can be contained within the Future Care Plan Summary document, and where it should be documented.

The Future Care Plan Summary is available on Clinical Portal and can be accessed and edited by anyone with a Clinical Portal account. All clinical staff should have access to Clinical Portal. Social Work staff should apply for a Clinical Portal account via their Line Manager to ensure they can access the system. Access has also been granted to HSCP Care Homes, Hospices and some third sector partners such a Macmillan Improving the Cancer Journey teams and Post Diagnostic Support Workers who support people living with dementia.

For professionals who do not have access to Clinical Portal (e.g. they work in an external organisation such as independent Care Homes or Carer Support Services) an [interactive PDF version of the Future Care Plan Summary](#) is available.

If NHSGGC or HSCP staff would prefer to use the PDF version in initial conversations (e.g. home visits) this is acceptable, however staff have a responsibility to ensure any information is transferred to the Clinical Portal system without delay.

7.4.1. Clinical Portal

7.4.1.1. How to set up an account

All clinical staff should have access to Clinical Portal. Social Work staff should apply for a Clinical Portal account via their Line Manager to ensure they can access the system. Access has also been granted to HSCP Care Homes, Hospices and some third sector partners such a Macmillan Improving the Cancer Journey teams and Post Diagnostic Support Workers who support people living with dementia.

Staff who do not currently have an account should speak with their Line Manager to get permission to apply for an account. Clinical staff can apply for access via [My Account on Staffnet](#).

If you are a Social Work Team Lead and unsure who you should contact in order to get Clinical Portal Access please discuss this with your Line Manager.

An [emodule has been created to give an introduction and overview of the Clinical Portal](#) system. Please note this does not specifically relate the Future Care Plan Summary, however will provide staff with a foundational knowledge of how to navigate Clinical Portal.

7.4.1.2. Viewing and Updating the Future Care Plan Summary on Clinical Portal

[Guide to updating Future Care Plans on Clinical Portal – PDF](#)

[Guide to updating Future Care Plans on Clinical Portal - Video](#)

If a Future Care Plan Summary has already been created, a “read-only” version can be found with the “Care Plans” section of the Clinical Documents Tree. All staff are encouraged to check on Clinical Portal to see if the document has been started prior to the initial meeting with the person.

Following an update in June 2025, the document on Clinical Portal is now called “Future Care Plan”, however some patients may still have an older version of the document on the system which will still be called the “Anticipatory Care Plan Summary”. These documents will sit under “Care Plans > Anticipatory Care Plan” if viewing documents in “category” view.

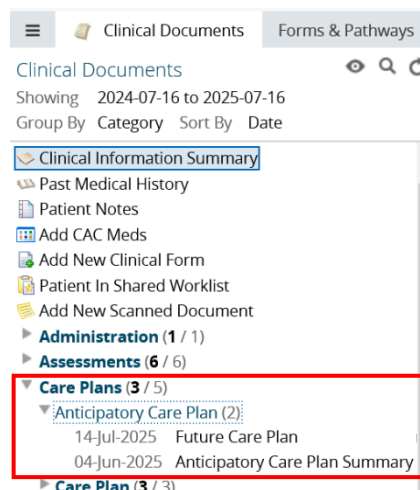


Figure 5. Document Tree on Clinical Portal.

Please note that if the Clinical Portal Document Tree is set to “Service” view, then any Future Care Plan will be found under “Acute Specialties GGC”.

If the Future Care Plan Summary needs updated or created for the first time, this occurs via the “Forms and Pathways” tab on Clinical Portal. Choosing “add/update Future Care Plan Summary” will allow staff to edit the document. Please note if you are updating an existing Future Care Plan Summary you must scroll to the end of the document and press “amend” in order to edit the document.

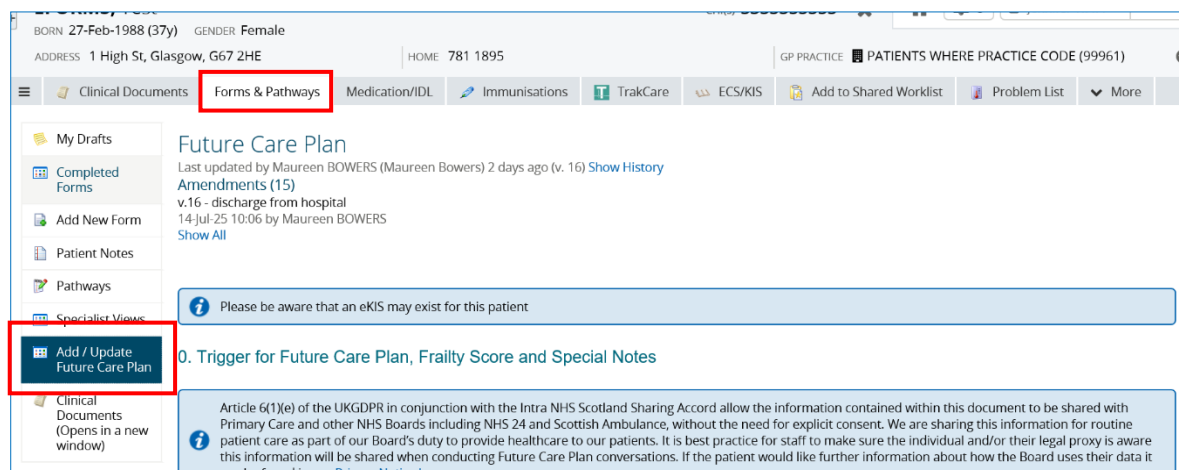


Figure 6. Forms & Pathways tab on Clinical Portal.

EFORMS, Test CHS 3333333333 Jennifer WATT LOGOUT

BORN 27-Feb-1988 (37y) GENDER Female ADDRESS 1 High St, Glasgow, G67 2HE HOME 781 1895 GP PRACTICE PATIENTS WHERE PRACTICE CODE (99961)

Forms & Pathways Medication/IDL Immunisations TrakCare ECS/KIS Add to Shared Worklist Problem List More

16-Dec-2024 QEUH Ward Based

Information Guidance Notes for views about hospital admission / views about treatment and interventions / family agreement

Has DNACPR been discussed?	Yes	Comments	Patient and family have discussed and are aware of views.
Is a DNACPR Form in place?	No	Comments	—
Refer to GP for further discussion re DNACPR	Yes	Comments	More information required - what this means and process. Will follow up with email referral to GP Practice.
Form Closed	No		

When you click to 'Complete' a copy of the Future Care Plan Summary will be sent electronically to the registered GP practice.

Amend Print

Figure 7. Amend button for Future Care Planning Summaries which have previous been created.

7.4.1.3. Changing to New Format of Future Care Plan Summary

In June 2025, the Future Care Plan Summary on Clinical Portal was updated to improve data capture and provide extra prompts to record related information on Power of Attorney and Treatment Escalation Plans (see [Section 7.2.3.1](#) and [Section 7.1.3](#)).

If a Future Care Plan Summary is being created for the first time, the new format will automatically be used. If an individual already has a Future Care Plan Summary using the old format, this document should be “closed” so that the new version of the summary can be used. To close the form, scroll to the bottom of the Summary and tick the “Form Closed” tick box.

Form Closed ☐

When this box is selected this ACP can no longer be edited

Figure 8. Form Closed Tick Box on the previous version of a Future Care Plan Summary (called the Anticipatory Care Plan or ACP) on Clinical Portal.

Closing previous forms may result in multiple forms available in the document tree, some of which may have different names (i.e. Anticipatory Care Plan Summary and Future Care Plan). Staff should review all available documents to gain as much information as possible.

If closing an old version, and creating a new form staff can note that there is an older version on file within the “Special Notes” section of the new document. They do not need to copy all previous information into the new form, staff should use their own discretion to transfer relevant information.

7.4.2. Information recorded in the Future Care Plan Summary

7.4.2.1. Staff Details

In order to help monitor Future Care Planning uptake across the Board Area we are asking staff to record some details in the Future Care Plan Summary such as job role and HSCP area/ directorate/ service. This data will allow us to run reports and share information to identify good practice and any areas which may require additional support.

Care Home and Hospice staff should select this as their “Job Role” and select the appropriate HSCP they are based in as their “Directorate”. This will help identify local engagement more easily.

7.4.2.2. Trigger for Future Care Planning

Staff are asked to record what triggered a Future Care Plan Summary to be created or updated. This is a mandatory field.

Identifying and monitoring common triggers for Future Care Plans will help us to establish trends within our population. This will allow us to plan targeted communication to specific individuals and the services who work with them.

By recording this information on the Future Care Plan Summary, staff can support their colleagues too, by providing context for conversations that have occurred. Staff can also review previous versions of the Future Care Plan Summary in order to better understand why certain topics have been approached or what triggered previous updates.

When a summary is first created, please do not select “Review/Update” as the trigger. This should only be selected when the summary itself is being reviewed and updated.

7.4.2.3. Identifying Author of Open Text Notes

In order to quickly track when information was updated, and by whom, please insert job role/team name and date prior to any new information being added to open text boxes such as “special notes” etc.

7.4.2.4. Deletion of Previous Information

If you feel new information supersedes past information (e.g. wishes regarding preferred place of care) then past information can be deleted.

7.4.2.5. Saving Future Care Plan Summary on Clinical Portal

Once you have inserted all relevant information, scroll to the bottom of the document and press “complete”. By doing so, an EDT alert will be automatically generated to the person’s GP informing them that new information has been added to the Future Care Plan Summary. If they wish, the GP Practice Team can then update the person’s Key Information Summary (KIS) to reflect that a Future Care Plan Summary has been created, or to document the information contained within the Future Care Plan Summary.

7.4.2.6. Adding Information to a Previous Summary

The Future Care Plan Summary should be a multi-disciplinary record which multiple people adding information over time. If you are adding information to a summary which has already been created then remember to add another “Review” box to allow you to add your own details.

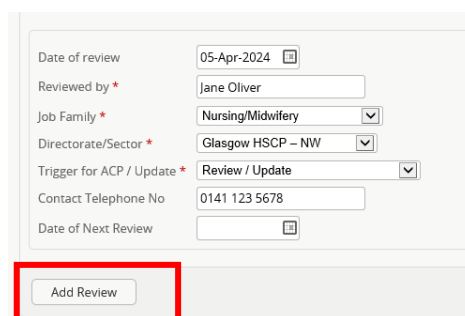


Figure 9. Add Review to any updated summary

You will also be asked why you are changing the summary at the top of the form – this is mandatory.

Amend Document

Summarise the changes you are making to this document *

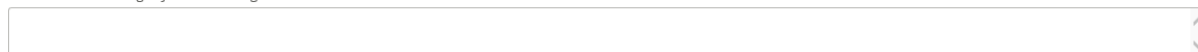


Figure 10. You must detail why you are updating information to a summary

7.4.3. Transfer to Key Information Summary

7.4.3.1. Why does information need to be stored on both systems?

In Scotland, the Key Information Summary (KIS) allows clinical information from the GP electronic record (Vision or EMIS) to be shared across different parts of NHS Scotland.

There are different components to the KIS, which include the Emergency Care Summary (ECS), current medical diagnoses, essential contacts, palliative care information, and the KIS ‘Special Notes’.

Within NHSGGC, the Future Care Plan Summary contains this information as well. However, unlike KIS, the Future Care Plan Summary can be accessed and edited by any professional with a Clinical Portal account. This ensures that a wider range of professionals can help to gather information which is useful to all services.

Once a Future Care Plan Summary has been updated on the Clinical Portal system, a copy of this will be automatically generated and sent through EDT to the named GP surgery. If they wish, the GP Practice Team can then update the person's Key Information Summary (KIS) to reflect that a Future Care Plan Summary has been created, or to document the information contained within the Future Care Plan Summary.

It is useful to have information on both systems as national NHS services such as NHS 24 and Scottish Ambulance Services may not have access to the local Clinical Portal system but will have access to KIS.

7.4.4. Key Tasks

Staff are asked to ensure information is updated on KIS in the following weeks. If the KIS has not been updated, a comment can be made within the Future Care Plan Summary "special notes". See Process Flowchart ([Section 15.1](#)).

Updating the KIS with information contained in the Future Care Plan Summary is at the discretion of the GP Practice Team, some colleagues may prefer to make a note in the KIS special notes indicating that a Future Care Plan Summary exists on Clinical Portal.

7.4.4.1. Primary Care

[GP Guidance for Updating KIS from Future Care Plan Summary on Clinical Portal – PDF](#)

GPs have primary responsibility for updating KIS as the system relies on Primary Care systems (Vision or EMIS). Given the large populations that Practices serve it can be impractical to expect GP Practice Teams to gather all necessary information directly from the person. This is why the Future Care Plan Summary has been created.

The Future Care Plan Summary offers opportunity to share workload between Primary, Community and Acute services as well as Social Work. It also acknowledges the different types of information which services routinely gather.

When information is updated or a new Future Care Plan Summary is created on Clinical Portal, a copy of this will be automatically generated and sent through EDT to the named GP surgery. This will appear on the DOCMAN system. This process

OFFICIAL - SENSITIVE: Operational

should be highlighted to all surgery admin support in order to ensure that members of the GP Practice Team are aware that a Future Care Plan Summary has been created.

Updating the KIS with information contained in the Future Care Plan Summary is at the discretion of the GP Practice Team. Some colleagues may prefer to make a note in the KIS special notes indicating that a Future Care Plan Summary exists on Clinical Portal.

If Practices use EMIS it is possible to copy and paste the information from the Future Care Plan Summary directly to the KIS using the following process:

Open the Summary document to view within the patients DocMan record

Press F2 twice on the keyboard to open up the Summary in Adobe Acrobat

Text in the PDF can then be highlighted for copy/paste

If there is information contained within the Future Care Plan Summary that a professional is uncomfortable adding to the KIS, they can contact the staff member who completed the Future Care Plan Summary update and ask for clarification. Details of who completed/updated the original Future Care Plan Summary will be available on the form.

7.4.4.2. Onward Referrals Including DNACPR

As part of a Future Care Planning conversation it may be appropriate to discuss preferences regarding cardiopulmonary resuscitation (CPR), including whether a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) should be completed.

A DNACPR is a document which prevents professionals from attempting to restart the heart if it should stop. Having a DNACPR does not prevent someone from receiving any other treatment including antibiotics or surgery.

These conversations can be sensitive and care should be given to ensure professionals have the appropriate knowledge, understanding and experience before commencing in these conversations. However if someone wishes to discuss this topic, appropriate steps must be taken to ensure preference are discussed and taken into account.

If a professional feels comfortable to engage in the conversation they should do so. If a professional does not feel best suited to have this conversation they should acknowledge that the person wished to discuss the topic further and ensure a referral is put in place for this to happen.

OFFICIAL - SENSITIVE: Operational

	25	
--	----	--

7.4.4.2.1. Who to refer to for further DNACPR discussions?

In most cases a referral should be given to the GP or other senior clinician involved in the person's care. This could be a consultant, district nurse or member of the palliative care team.

A DNACPR is a document and will need to be signed by a senior clinician in order to validate it. A DNACPR form cannot be signed unless a discussion has taken place between the individual and the senior clinician. If a member of staff does not have the authority to sign the document they must ensure a referral is put in place for the appropriate clinical profession to have a further discussion with the individual. In this instance it is best practice to also add this information to the Future Care Plan Summary as well, in case an emergency arises before the conversation can take place and documentation signed.

It is best practice for the professional who made the referral to follow up at a later date to ensure this process is complete.

7.4.4.2.2. Other Referrals

If onward referrals are required for other aspects of someone's care and treatment (e.g. discussion regarding home care, mobility equipment etc.) it is again best practice for the professional who made the referral to follow up and ensure this process is complete. If staff are unsure as to the correct referral process they should speak with their line manager.

8. Recording the Future Care Planning Journey

Whilst it is important to record the detail of Future Care Planning conversations in the Future Care Plan Summary documentation (either PDF or Clinical Portal), it is also important to record where someone is in their Future Care Planning journey, and any progress has been made. This includes recording when someone is engaged in an overview conversation, in the process of completing a Future Care Plan Summary and even if/when the Future Care Planning is reviewed.

By documenting these steps, colleagues can quickly ascertain if further conversations are required and HSCP or individual teams can monitor their own Future Care Planning activity.

Where is the Future Care Planning Journey Recorded?

A dossier has been created to track the number of Future Care Plan Summaries are created in each locality. However this only tracks when a plan is first created and if/when a review occurs. It also tracks how many people refuse a summary (see [Section 6.3](#)).

Services which use CNIS or EMIS has the capability to record additional steps in Future Care Planning journey, and local teams and service may created their own monitoring systems.

If you are unsure as to how you should be recording the Future Care Planning journey, speak with your line manager.

8.1. Collection of Data for Local Reporting

Depending on local reporting requirements, the overall BI dossier may give teams enough information. However there may be requirements for data to be reported via CNIS or EMIS reporting, especially when trying to account for the amount of people who have either refused a plan, or not been offered one.

It is also best practice for the commencement and/or completion of a Future Care Planning to be incorporated into patient record held by the service.

8.1.1. EMIS

Any team using EMIS can record progress by using the relevant EMIS code (see [Section 8.2](#) for definitions). Codes should be inputted alongside any other notes being recorded as part of an interaction. They can be inputted in either “consultation”, “history” or “examination” depending on the context of the interaction.

It is important to provide context to the EMIS code as well in order to ensure colleagues have a full understanding of the situation.

[A video of how to record information on EMIS is available.](#)

Please note that even if staff record that someone refuses to have a plan on EMIS they should still record this on Clinical Portal as well.

8.1.2. CNIS

For District Nursing Teams, it is possible to report the progress of Future Care Planning Conversations on the Palliative Care tab on CNIS (see [Section 8.2](#) for definitions).

[A video of how to record information on CNIS is available.](#)

Please note that even if staff record that someone refuses to have a plan on CNIS they should still record this on Clinical Portal as well.

Staff may also use the CNIS dashboard to identify patients who may have incorrect codes recorded. For example CNIS might be recording that the Future Care Plan is complete, however there is no record on Clinical Portal.

All CNIS users have a responsibility to ensure that the information on both systems is correct, and rectify any issues as soon as possible.

8.2. What Steps Are Recorded?**8.2.1. EMIS**

There are several steps which should be recorded on EMIS systems. Here is a list of steps and their definition.

Please note that the terminology of the EMIS codes will remain “Anticipatory Care Plan and ACP”

Code	Definition	Further context required
Has anticipatory care plan	Future Care Planning already in place from previous time/service	From when?
Anticipatory care plan offered	Future Care Planning conversation held with person about what it is, benefits etc.	Patient/Family attitude
Anticipatory care plan declined by patient	Person declines a Future Care Planning at this stage	Reason?
Anticipatory care plan completed	Future Care Plan Summary created by staff member and shared (either PDF or Clinical Portal)	If PDF please state who and when information was shared with (e.g. shared with GP via email)
Anticipatory care plan information shared	Verification of information being transferred to Key Information Summary (KIS).	Date of Confirmation
Anticipatory care plan information not shared	Key Information Summary (KIS) has been checked and found to be lacking updated information from Future Care Plan Summary*	Have any steps been taken to resolve this?
Review of anticipatory care plan	Future Care Plan Summary reviewed	Any update required

*In instances where the KIS does not match the Future Care Plan Summary, please note this, including the date, in the Future Care Plan Summary document so that services are aware of this possible disparity.

8.2.2. CNIS

There are several steps which should be recorded on CNIS systems. Here is a list of steps and their definition.

Term	Meaning
Completed	A summary has been started on Clinical Portal. There may still be information that requires to be added to the form, however there is a record in place.
In Progress	The subject of future care planning has been raised with the person and/or the people who matter to them and there is an agreed plan in place to revisit the conversation and begin to populate the form on Clinical Portal. This could include leaflets/blank copies of the Summary being left with the person/those that matter to them to review.
Declined	If someone declines to engage in a future care planning conversation/make a plan. This should still be recorded on the summary on Clinical Portal alongside a reason as to why they have declined. There is a specific question on the Summary to record this information.
No	This status may be used prior to engaging someone in a discussion, however once outcome of the discussion is known this status should be changed.

8.3. Responsibility

8.3.1. HSCP Leads

It is the responsibility of each individual HSCP Lead to monitor this data collection and report back through their own governance routes. If issues are identified either in data collection, or team activity, it is their responsibility to work with identified local leads to rectify issues.

HSCPs will monitor their local activity against their local implementation plans and agree appropriate targets and governance routes.

8.3.2. Identified Local Leads (i.e. Team Leads, Service Managers etc.)

It is the responsibility of each individual Team Lead to ensure their data is recorded appropriately. This may involve monitoring EMIS or CNIS reports, or viewing the BI dossier to review numbers of plans being created.

Team Leads may wish to delegate this task to a Future Care Planning Champion within their own team, however ultimate responsibility for data collection remains with the Team Lead.

9. Review

The Future Care Plan Summary is a live document which can be amended as the views, wishes and situation of the person change.

9.1. When to Review

Whilst there is no required review period it is best practice to review and revisit Future Care Planning conversations in the following instances:

- During initial consultations of new referrals
- Alongside any review which occurs as part of the services processes
- Appointments to discuss any new diagnosis

9.2. Responsibility

It is the responsibility of any professional working with individuals to ensure Future Care Plans are reviewed when necessary. It is also their responsibility to ensure any updates are recording on the Future Care Plan Summary on Clinical Portal.

If referrals are necessary as part of the review process it is the responsibility of the reviewer to make these referrals. It is also best practice to follow up at a later date to ensure action is taken (See [Section 7.6.4](#))

10. Future Care Plans in Care Homes

The process for commencing a Future Care Planning conversations within Care Homes is largely similar to any other area (see [Section 6](#)). There may be some variation in the documentation used to record the content of the conversation, as well as the practical arrangements required to ensure information is uploaded to systems and can be easily shared.

10.1. Clinical Portal

HSCP Care Home senior staff have been given Clinical Portal accounts in order to ensure that residents' information can be uploaded to the system. If you work in a HSCP Care Home and believe you should have an account for this purpose then speak to your Line Manager.

Staff should ensure that they have completed the appropriate training in order to navigate the system (see [Section 7.5.1.1](#))

10.2. PDF Summary

All care homes are likely to have their own paperwork for residents. It is not the intention of NHSGGC and local HSCHPs to standardise paperwork for independent businesses.

Instead it is proposed that Care Homes can choose to include the [PDF version of the Future Care Plan Summary](#) as part of resident's files, using information already gathered/held by the organisation to inform the documentation. This PDF file can then be shared with either resident's GP, or in some instances CHLN, to transfer information to the Clinical Portal and KIS systems.

It is hoped that this summary document can provide a brief overview of preferences regarding treatment and place of care, which will enable care home staff to make appropriate choices in emergency situations (e.g. whether to call an ambulance, start meds, call family etc.)

10.3. LES v non LES Care Homes

Some Care Homes may be part of a Local Enhanced Service (LES) whereby one GP Surgery has responsibility for all residents within a Home (as oppose to each resident retaining their original GP). In these cases it may be easier to secure a pathway for Future Care Planning information to be recorded and stored (either on Clinical Portal initially or directly to KIS) for all residents. For homes serviced by multiple GPs (i.e. non-LES Homes), agreement will need to be made with each individual practice.

The information recorded in the Future Care Plan Summary is directly comparable to the KIS, therefore if Homes wish to use this document as part of their files it may streamline information transfer to the GP which can be useful regardless of how many GPs work with the Home.

10.4. Care Home Liaison Nurse (CHLN) Role

CHLNs play a valuable role in helping to support Care Homes create and share Future Care Plans for all residents. Please be aware practice may vary between

HSCPs depending on local process and capacity, however here are suggested activities CHLNs and Care Homes can undertake as part of good practice.

CHLNs can support staff to engage in Future Care Planning conversations with residents and their families, signposting staff to training and resources where appropriate.

CHLNs can review resident files to ensure all residents have an accurate and up to date Future Care Planning, highlighting those who do not to Care Home staff. Particular focus should be given to residents who are deteriorating and/or requiring palliative care.

CHLN can check hospital admission dashboards to follow up with residents and check if treatment plans reflect Future Care Planning notes. If residents do not have a Future Care Planning, CHLNs can support Care Home staff to begin creating one.

CHLNs can assist Care Home staff in sharing Future Care Planning information with GPs. This could involve ensuring Care Homes have access to helpful and appropriate paperwork such as the Future Care Plan Summary. In some cases this may extend to uploading Future Care Planning Summaries to Clinical Portal however this will depend on capacity.

10.5. Care Home Collaborative

The Care Home Collaborative was established to work with and further support care homes during and in recovery from the COVID-19 pandemic. The Collaborative is based on the principle of bringing people together across the many different groups, organisations and professions who are already working alongside the care home sector and for those groups to work collaboratively towards a shared goal.

The Care Home Collaborative have various working groups, many of which align with the principles of Future Care Planning and may use these to promote residents' health and wellbeing.

To find out more about the work of the Collaborative you can visit their [webpages](#) or email ggc.chccontact@ggc.scot.nhs.uk.

10.6. Future Care Planning Champions in Care Homes

Management within Care Homes are encouraged to recruit Future Care Planning Champions to support colleagues to engage with residents and their families on this important conversation. For more information see [Section 4.4](#).

10.7. The 3 Question Project in Care Homes

Alongside all of the regular topics which should be discussed (See [Section 7.1.](#)), Care Homes are encourage to discuss 3 possible scenarios with residents and their families in order to establish possible escalation plans if a crisis occurs. These scenarios are:

- If a resident had a sudden collapse (such as a stroke or a heart condition,)
- If a resident had a serious infection that was not improving with an antibiotic tablet or syrup
- If a resident were not eating or drinking because they were now very unwell

For each question there are three suggestions of possible plans for each of these situations:

- Keep the resident comfortable, treat any pain or other symptoms and care for the resident at home.
- Contact NHS24/GP (or family) to help decide whether to send the resident to hospital instead of dialling 999.
- Send the resident to hospital for investigations and treatment such as drips and treatment into vein.

The resident (and their family) might wish to have different plans for each scenario, this is okay.

By thinking about these situations beforehand, staff have time to discuss what really matters to our residents and their friends and family. Everyone has the opportunity to ask questions and find out about what treatment can be delivered in our Care Homes – this might be more appropriate that sending people to hospital which can be stressful.

Staff can record the answers to the three questions in the Future Care Plan and share this information with other services including the GP.

These questions are based on an NHS Lothian project called “[7 Steps to ACP](#)”.

There are tools available to support areas implement the 3 Questions Project available on the [sharepoint site](#).

10.8. Training for Care Home Staff (see also [Section 12](#))

General Future Care Planning training is available to all Care Home staff. This includes access to the Future Care Planning e-module and recorded sessions.

Information for both of these opportunities can be found on the [Future Care Planning Training Hub](#) on the NHSGGC Future Care Planning webpages.

Local teams, as well as the Care Home Collaborative provide various training to Care Home. Some of this may include information about Future Care Planning or communication skills. It is advised that care home managers contact relevant HSCP contacts to enquire about opportunities for further training within their own areas.

10.9. Good Practice Example for Care Homes

A [library of example Future Care Planning Summaries](#) has been created which cover a range of various scenario, including a Future Care Plan Summary example for a [Care Home Resident](#).

11. Future Care Planning in Children's Services

Future Care Planning can act as a valuable advocacy tool in promoting the appropriate decision making, therapeutic intervention and treatment escalation in a child or young person who has a known life limiting condition. There is a clear focus on what is important to the child, young person and family as a whole.

Future Care Plans can be utilised at any point following diagnosis. They are best initiated in a time of stability but may be pre-empted following an episode of instability or deterioration. NHSGCC Children's services uses a nationally agreed template, rather than the NHSGGC Future Care Plan Summary and has an established pathway to ensure this information is shared with relevant services.

11.1. Future Care Planning documentation used in Children's Services

The document is designed to be fluid in nature. Preferences and management plans may require changed in order to continue to align to the child or young person's quality of health. A copy of [the Children's and Young Person's ACP](#) can be found online on the Healthcare Improvement Scotland webpages.

The Future Care Planning has progressive sections. Personal demographics and key information lead on to a summary of the current condition with an opportunity to document relevant past medical history. Preferred places of care and plans regarding acute deterioration management are then discussed. The document then enables direction with how specific anticipated episodes of acute illness should be managed and escalated. A child or young person may require multiple acute illness plans completed that could span across many considerations such as; respiratory, neurological, gastrointestinal or pain. Children, young people and families have a section where 'what matters to me' can be clearly represented. For some families documenting preferences and thoughts regarding care around death care can also be captured.

The national Managed Clinical Network PELiCaN –Paediatric End of Life Care Network is currently undertaking a review of the template across key Scottish stakeholders. This review incorporates the development of professional guidelines, edits to the existing template and a summary document that details specific treatment escalation consideration if a child acutely deteriorates. This work is ongoing and will be reported on by PELiCaN.

11.1.1. Creation of a Future Care Plan in Children's Services

A coordinator is identified for each Future Care Plan. This role facilitates the development of the document and approaches all relevant teams to contribute with their area of expertise. All changes to the plan are made via the Future Care Planning coordinator in order to mitigate conflicting advice being documented. The coordinator is most effective when they well known to the child, young person and their family, with a pre-existing, sustainable professional relationship. The coordinator works directly with the family to support their wishes and preferences being accurately captured, shared and developed within the Future Care Plan.

The document should be used for whatever section is helpful and does not need to be completed in full. It should be fluid and be able to be updated or added to as is required or requested. The end of the document has a list of professional contacts for the child or young person.

11.1.2. Conversations regarding resuscitation and CYPADM

Future Care Planning is an effective way to address significant questions regarding a child or young person's prognosis and changing condition. It can be a natural progression to significant conversations regarding resuscitation. A Children/Young People Acute Deterioration Management (CYPADM) form is a Consultant lead form that provides guidance regarding the appropriate resuscitative interventions that could be attempted in an acute deterioration. Neither a Future Care Planning nor CYPADM hold any legal mandate and are both advisory in nature. CYPADM's should also be uploaded to Clinical Portal with an alert placed on Trakcare. Scottish Ambulance Service and GP's must also be emailed a copy.

11.1.3. Sharing Information Across Children's Services

The coordinator has the responsibility for distributing the Future Care Plan for comment during its development and dissemination once agreed as a live document. The coordinator must email Scottish Ambulance Service and the GP a copy. The Community Children's Nursing Team and Hospice should also be emailed a copy if the child or young person has been referred to their services. The coordinator facilitates a pdf of the document to be scanned into Clinical Portal under 'care plans'

and an alert placed on Trakcare to advise of its existence and where it can be found. Future Care Plans should be updated annually and beforehand when required.

Please note that the Future Care Plan from Children's Services will be a scanned document, not an electronic form.

11.2. Future Care Planning for Antenatal Services

An NHSGGC antenatal Future care plan exists for families who receive a devastating diagnosis of a life limiting condition in pregnancy. There is no national template as yet, but work continues through the Neonatal Managed Clinical Network progressing this. Antenatal Future Care Plans require the collaboration of multiple teams; Fetal Medicine, Obstetrics, Labour Ward, Neonates, Community Midwifery, Primary Care and Specialist Palliative Care Teams.

11.3. Transitioning to Adult Services

Transitioning to adult services can be a stressful period for young people and their families. There may be changes in the services which are provided or the pathways they will be placed on. Future Care Planning conversations can help to manage expectations and ensure appropriate plans are put in place.

If a young person already has a Future Care Plan from Children's Services, this can be used as the foundation for completing the Future Care Plan Summary used in Adult Services. A young person can use the Future Care Planning documentation from Children's Services for as long as they wish, however it is best practice to note in the Future Care Plan Summary on Clinical Portal if someone has a Future Care Plan from Children's Services uploaded on the platform.

12. Training

12.1. E-Learning

An online learning module has been created to provide all staff with a general understanding of Future Care Planning. This module is suitable for any professional in any role or banding. It can also be completed by professionals out with the NHS or HSCPs.

It can currently be accessed via:

[Future Care Planning Website](#)

[Learnpro](#) – GGC:028 Future Care Planning

12.2. Bite-Sized Learning

Future Care Planning encompasses many different topics and there are systems that staff need to use to record this information. A series of bite-sized learning sessions have been developed which include online information, and in some cases recorded sessions which staff can access.

There are also training packs and resources that have been developed for staff who wish to upskill their teams and colleagues by running face to face training. These resources can be accessed via the [Sharepoint Site](#) (please note this is only accessible to NHSGGC staff).

12.2.1. Introduction to Future Care Planning

This session provides an overview of what Future Care Planning is, who it is for and why it is important to plan for future health and care.

[The interactive SWAY is available here.](#)

12.2.2. Clinical Portal Walkthrough

This session demonstrates how to access the summary on Clinical Portal, taking participants through each section and suggesting information that can be included.

[The recording can be accessed here.](#)

12.2.3. Rockwood Clinical Frailty Scale Overview

Identifying people as 'frail' can be misleading and often creates a picture of someone who has not aged well. People living within the 'spectrum of frailty' can be supported with timely and targeted interventions and if we screen people early enough, we can sustain and even reverse someone's level of frailty.

We are encouraging all health and social care practitioners to screen for frailty by using the Rockwood Clinical Frailty Scale (CFS) and support people to have conversations about their future care.

This session gives an introduction to the CFS, examples of people at different points on the scale and discuss how the CFS can be recorded as part of the Future Care Plan.

[The recording can be accessed here.](#)

[The interactive SWAY is available here.](#)

12.2.4. Power of Attorney Overview

Power of Attorney is an important part of any Future Care Planning conversations. This session discusses how to get started with the process and how it can benefit everyone.

[The recording can be accessed here.](#)

[The interactive SWAY is available here.](#)

You can also find more information about Power of Attorney including Frequently Asked Questions on the [NHSGGC webpages](#).

12.2.5. CNIS Codes

For staff using CNIS, it is important to correctly document people's Future Care Planning journey. This sessions demonstrates how to update the system and what codes to use.

[The recording can be accessed here.](#)

[The interactive SWAY is available here.](#)

12.2.6. EMIS Codes

For staff using EMIS, it is important to correctly document people's Future Care Planning journey. This sessions demonstrates how to update the system and what codes to use.

[The recording can be accessed here.](#)

[The interactive SWAY is available here.](#)

12.3. Other Training Opportunities

12.3.1. For All Staff

There are lots of training opportunities on a range of topics. Self-directed emodules are available via Learnpro. Teams within NHSGGC also deliver training which may be useful to help prepare staff for some of these conversations. Visit the Palliative Care [education pages](#) to find out what is available or email info@palliativecareggc.org.uk.

There are also a range of [recorded webinars](#) available to watch on the Future Care Planning webpages.

12.3.2. Registered Professionals Working in Care Homes

There is training available to registered professionals working in Care Homes which is delivered by the NHSGGC Macmillan Nurse Facilitators. These sessions focus on advanced communication skills including Future Care Planning conversations.

For further information contact info@palliativecareggc.org.uk

12.4. Other educational resources

Please view the NHSGGC Future Care Planning Webpages for more educational resources including a list of [other suggest learning opportunities](#).

13. Quality Assurance

It is important that Future Care Plans are not viewed as a tick-box activity. The value of the document comes from the content recorded within it. At times of crisis this form can serve as a guide to help everyone make the right decisions, particularly if the person themselves cannot communicate their own wishes and preferences.

Research has been conducted to ascertain what information professionals feel would be useful to record within the Future Care Plan Summary. [A guide](#) has been created to help staff understand the various topics which could form Future Care Planning discussions. (See [Section 7.1.1](#)).

Local arrangements will be made to monitor the quality of information contained within the summaries.

13.1. Quality Assurance Tools

We recognise that in order to be truly person-centred, the details within a Future Care Planning will depend on where an individual is in their health journey. For example, not everyone may be at a stage where it would be appropriate to discuss DNACPR or preferred place of death.

Given this potential variation in Future Care Planning content, creating a nuanced audit tool can be difficult.

Local arrangements may develop a tool, however there is [a checklist](#) which can be used by teams and services to review the content of plans, and identify areas of improvement. A [simplified audit tool](#) has also been created which teams are welcome to download and use.

13.2. Example Future Care Planning Summaries

A range of [example Future Care Planning Summaries](#) have been created to help staff understand what information should be recorded in order to form a robust Future Care Planning.

[Alan Fulton](#) – An older man who cares for his wife.

[Henry Harris](#) – An older man living with frailty.

[Monica Hill](#) – A lady with breast cancer receiving support from a local hospice.

[Dave Langton](#) – An older man living in sheltered accommodation.

[Elizabeth MacDonald](#) – An older lady with COPD.

[Ali Malik](#) – A young adult transitioning between child and adult palliative care services. You can also view an example of a [Child and Young People Acute Deterioration Management \(CYPADM\) form](#).

[Charles Menzies](#) – An older widow who is living independently with no known conditions.

[Duncan Moore](#) – A middle-aged man with a new diagnosis of Diabetes Type 2.

[Jacqueline Morrow](#) – A parent carer with a daughter on the autistic spectrum.

[Sophie Morrow](#) – A young woman with autism.

[Margaret Quinn](#) – An older lady living with dementia.

[Sarah Rosenshine](#) – An older lady living with osteoporosis.

[Cathy Steel](#) – An older frail lady receiving Palliative Care.

[Paul West](#) – A middle-aged man recovering from cancer.

[Tom Williams](#) – A Care Home Resident.

[Dougie Wilson](#) – Adult living with a learning disability

14. Supporting Guidance

14.1. Hyperlink index

14.1.1. Future Care Planning Documents and Guidance

[PDF version of the Future Care Plan Summary](#)

[Future Care Plan Summary guide](#)

[Children's and Young Person's Future Care Planning](#) (National Template)

[Guide to updating Future Care Plans on Clinical Portal – PDF](#)

[Guide to updating Future Care Plans on Clinical Portal - Video](#)

[GP Guidance for Updating KIS from Future Care Plan Summary on Clinical Portal – PDF](#)

[DISCUSS Guides](#)

[Future Care Plan Checklist](#)

[Simplified Audit Tool](#)

14.1.2. Future Care Plan Summary Examples

[Alan Fulton](#) – An older man who cares for his wife.

[Henry Harris](#) – An older man living with frailty.

[Monica Hill](#) – A lady with breast cancer receiving support from a local hospice.

[Dave Langton](#) – An older man living in sheltered accommodation.

[Morag Smith](#) – An older lady with COPD.

[Ali Malik](#) – A young adult transitioning between child and adult palliative care services. You can also view an example of a [Child and Young People Acute Deterioration Management \(CYPADM\) form](#).

[Charles Menzies](#) – An older widow who is living independently with no known conditions.

[Duncan Moore](#) – A middle-aged man with a new diagnosis of Diabetes Type 2.

[Jacqueline Morrow](#) – A parent carer with a daughter on the autistic spectrum.

[Sophie Morrow](#) – A young woman with autism.

[Margaret Quinn](#) – An older lady living with dementia.

[Sarah Rosenshine](#) – An older lady living with osteoporosis.

[Cathy Steel](#) – An older frail lady receiving Palliative Care.

[Paul West](#) – A middle-aged man recovering from cancer.

[Tom Williams](#) – A Care Home Resident.

[Dougie Wilson](#) – Adult living with a learning disability

14.1.3. Further Topic Specific Information

[Future Care Planning](#)

[Cardiopulmonary Resuscitation \(CPR\)](#)

[Planning for Unexpected Events](#)

[Hospital Discharge](#)

[Power of Attorney](#)

[Carer Support](#) (including [Carer Support Plans](#))

[Wills](#)

[Supporting Someone Who is Dying](#)

[What To Do When Someone Dies](#) (including [Funeral Planning](#))

[Bereavement Support](#)

[Organ and Tissue Donation](#)

[Emotional Support](#)

14.1.4. Professional Guidance

[Guidance for professionals who need to assess capacity](#) (Scottish Government)

[Guidance for GPs and Primary Care staff regarding KIS](#) (Healthcare Improvement Scotland)

14.1.5. Training Links

[Future Care Planning Training Hub](#)

[Future Care Planning Emodule](#)

[Future Care Planning SWAY](#)

[Clinical Portal Walkthrough Recording](#)

[Rockwood Clinical Frailty Score Overview Recording](#)

[Rockwood Clinical Frailty Score Overview SWAY](#)

[Power of Attorney Overview Recording](#)

[Power of Attorney Overview SWAY](#)

[CNIS Codes and Walkthrough Recording](#)

[CNIS Codes and Walkthrough SWAY](#)

[EMIS Codes and Walkthrough Recording](#)

[EMIS Codes and Walkthrough SWAY](#)

[Learnpro](#)

[RED-MAP](#)

[Sage & Thyme](#)

[Other suggest learning opportunities](#)

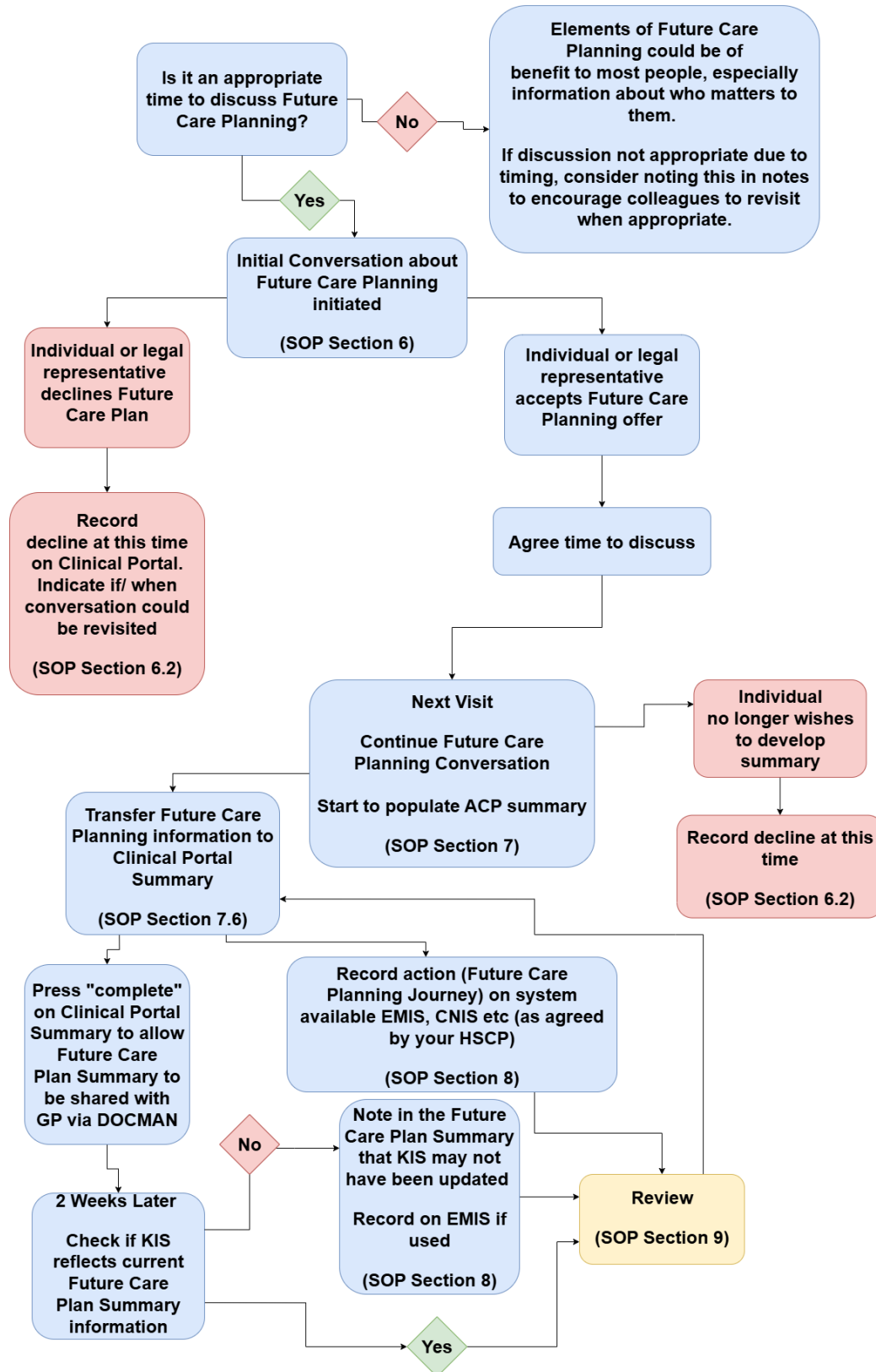
14.1.6. Website Links

[NHSGGC Webpages](#)

[Future Care Planning Sharepoint Site](#) (only accessible to NHSGGC employees)

15. Annex

15.1. Process Flowchart



15.2. Updates to Previous SOP Versions

15.2.1. Update – July 2022

Alongside an update to all hyperlinks, further content has been added in the following sections:

- Section 6
 - [Recording when someone does not wish to have an Future Care Planning](#)
- Section 7
 - [Update regarding Frailty Assessment](#)
 - [Clarification on the need for consent to share information](#)
 - [Changing from older version of Future Care Plan Summary to new version](#)
 - [Additional information recorded in Future Care Plan Summary](#)
 - [Update of Screenshot to reflect new Future Care Plan Summary](#)
- Section 10
 - [Clarification on role of Care Home Collaborative](#)
- Section 11
 - [Future Care Plans in Children's Services](#)
- Section 12
 - [Description of additional training opportunities](#)
- Section 13
 - [Additional example Future Care Planning Summaries](#)
 - [Further detail on Future Care Planning Quality Assurance Audit Tool](#)
- Section 15
 - [Flowchart updated to reflect removal of consent question](#)
 - [Annex of update changes](#)

No information has been removed.

15.2.2. Update – Aug 2025

Terminology with SOP has been updated to replace “Anticipatory Care Planning” with “Future Care Planning” as per CMO directive (September 2023).

Update to Future Care Plan document on Clinical Portal has been reflected ([Section 7.5](#))

Information on where support and training is available has been updated to reflect the discontinuation of dedicated Future Care Planning support from the HomeFirst Programme.