ANTICIPATORY CARE PLANNING

EMPOWERING, ENABLING AND ENHANCING CARE

LEADING THE WAY TO BETTER HEALTH CARE IN LANARKSHIRE

PROJECT EVALUATION REPORT

MAY 2013

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Executive Summary

This report presents the Anticipatory Care Planning project within Lanarkshire from May 2012 to May 2013. The report describes the drivers behind the ACP project, the work undertaken and demonstrates the findings with recommendations for future work.

It is becoming increasingly clear that change is necessary for NHS Scotland to effectively respond to future care needs for people living with long term conditions. To do this, processes must be established that will sustain care delivery and care quality over the coming years and that these are safely and effectively delivered whilst maintaining excellence in standards of care.

In Lanarkshire there is recognition that proactive approaches such as Anticipatory Care Planning (ACP) are required which incorporate joint working with all service users and providers in all care settings, to address the above implications whilst being mutually beneficial to all.

Anticipatory Care Planning (ACP) demonstrates shared decision making through collaborative process to support a self management approach to personal health. Encouraging individuals with long term health needs to be cognisant of potential changes in their own health and wellbeing and to prioritise what is important to them. This process also allows effective communication of personal choice, practical need and sharing of key information to those who provide care.

This project demonstrates that continued focus is required in this area to achieve cultural change which will influence professional and individual behaviour and attitudes towards health. Changes which would enable patients through the provision of information, guidance and support, to be confident key decision makers in the planning and delivery of their own care.

Anticipatory Care Planning is patient centred, patient focussed and patient led, and enables positive involvement and communication of preferred wishes and personal goals for care.

Although this project has delivered the aims and objectives set by the project sponsor, further work is required to ensure the necessary infrastructure is in place to sustain the ACP ethos in Lanarkshire over the future years. There needs to be continued expert advice and support available to all care settings with regard to ACP information, awareness and implementation methods and to ensure sharing of good practice. ACP may help towards shifting the balance of care and assist in the strategic planning for future health needs for our ageing population however the focus of ACP must remain on patients, their goals for care and their preferred wishes.
ANTICIPATORY CARE PLANNING (ACP)

BACKGROUND AND PURPOSE OF PROJECT

With an estimated increase in the number of people living with a long term health condition there needs to be a radical change to the models of care to support people with Long Term conditions (BBC News Politics March 14 2013). NHS Lanarkshire fully recognises this need for change and alongside the aims and objectives for Reshaping Care for Older people have incorporated steps to improve Anticipatory Care Planning (ACP) in Lanarkshire.

ACP can be regarded “as a philosophy which promotes discussion in which individuals, their care providers and those close to them, make decisions with respect to their future health or personal and practical aspects of care” (Scottish Government 2011).

This can take many forms such as ranging from health maintenance and screening programmes such as keep well, enhancing the management of long term conditions and in respecting preferred place of care and end of life care. NHS Lanarkshire has taken a proactive approach to improve care for older adults and work in partnership with individuals with a long term health condition and their carers. The aims for this proactive approach are to help identify early any circumstances which may have a negative or detrimental impact on the health and wellbeing of an individual and on their long term health condition. This will be supported by developing robust strategies to avoid unscheduled acute hospital admission and also to alleviate concern and uncertainty for individuals and their carers.

Implementation and embedding the use of anticipatory care in NHS Lanarkshire is one such proactive approach. The intention for which is to offer every patient with a long term health condition an ACP which can be in the form of a self management plan through to end of life care plan.

ACP is a process which enables meaningful discussion and recording of future healthcare wishes and preferences in advance to a deterioration of health. This process may help to empower and enable individuals to make informed choices about their own health and wellbeing and discuss any concerns with those close to them or involved in their care. This includes respecting individual choice and embedding dignity and care in practice. Essentially this captures all the essential qualities and requirements for establishing a robust mechanism for person centred care, whilst including best practice to build on and improve care in Lanarkshire.

Furthermore ACP incorporates the strategies outlined in “A Healthier Future”, 20:20 Vision and NHS Lanarkshire Quality Ambitions. All of which recognise the need for “working with people to ensure shared responsibility for prevention, anticipation and self management” (A Healthier Future Framework 2012).

NHS Lanarkshire’s 4 Strategic aims:

These strategic aims are the main drivers behind the Anticipatory Care Planning Project within Lanarkshire, and provide the purpose, scope and focus for the project.
Anticipatory Care Planning Project

Project Definition and Aims

The aims and objectives of this project were based on the recommendations from the Anticipatory Care Plans in Lanarkshire Evaluation Report in 2010.

These recommendations included:

- To facilitate and support further implementation of anticipatory care planning in Lanarkshire and embed in practice.
- To support the use of ACP’s in Care Management
- To support Care Managers in Primary Care, Acute Sector and wider community groups to facilitate ACP implementation.
- To implement a mechanism of capturing ACP activity and to ensure this is firmly in place.
- To ensure there is a process in place to capture and record 5 key areas of information contained within ACP and shared with all relevant agencies.

One of the key objectives of this project was to firmly implement and embed ACP use in practice. In doing so ACP would be regarded as integral to best practice and the standard in the provision of person centred care. More importantly the use of ACP in practice should never be regarded as a tick box exercise, but essential to providing safe and effective care for individuals with a long term health condition.

This project fully recognised that “to meet the needs of the increasing ageing population and the challenges around health inequalities” Lanarkshire “needs to shift the balance of care”. Essentially improve and establish the “focus of healthcare towards prevention and supported self management”. This will assist “to improve people’s health and ensure quality healthcare services can be sustained now and in the future” (NHS Lanarkshire Strategic Framework 2012).

This can only be achieved though a better awareness and understanding of anticipatory care and the benefits of having a plan in place.

“We have engaged with service users and their families in an attempt to promote the advantages of ACP’s in a more positive way...We have initiated a programme of ACP training within our home which is proving to be successful.”

Feedback from ACP questionnaire. Care Home Manager North Lanarkshire.
Mr and Mrs Steel discussing ACP document following Mr Steel’s discharge from hospital.

“I’m pleased to know that my preferences will be considered in the event that I am unable to make decisions for myself. More importantly that my wife and family are aware of my choices for the future and an ACP is an excellent way of capturing these.”

Mr William Steel Age 75

Project scope – Methodology

The main areas of focus included:

- To Embed ACP understanding and use in Lanarkshire Care Homes and Community Nursing.
- To liaise and establish base line data of current ACP knowledge and use in Lanarkshire within Care Home settings.
- Facilitate ACP awareness within acute settings, district nursing teams and wider groups e.g. Carers groups.
- To discuss and implement appropriate measures to deliver effective change.
- To liaise and empower care providers to confidently initiate and discuss ACP within service delivery.
- To liaise and facilitate ACP knowledge, skills and ability to enable implementation of plans.
- To establish a robust system to ensure ACP is accepted as integral to a person centred care pathway.
- To liaise and actively promote ACP as individual, personal and central to how future care needs are met in Lanarkshire.
- To establish a mechanism to enable data capture of individual choice, preferences and wishes.
- To dispel the widely held belief or understanding that ACP is only for end of life discussion and decision making process.
To improve effective communication between individuals with a long term health condition, carers and care providers.

To proactively reduce avoidable acute hospital admissions. In the event of a necessary admission that this is managed within the required time frame to ensure individuals can return to their preferred place of care.

To influence a robust system of electronic ACP data sharing and reporting. This will be achieved by liaising with Information Services to analyse data for reporting to NHSL performance framework.

This project was focused within Community and Primary Care settings. With the exception of raising ACP awareness and improving associated communication skills, the outlined implementation methods were excluded from acute settings due to timescale limitations.

Methodology of approach

Project plan

This project was underpinned by the 3 main NHS Scotland Quality Strategy ambitions. This being that care provision is a prerequisite criteria enabling person centred, safe and effective care (NHSS Quality Strategy Ambitions).

The project was set up in line with NHSL project management policy and methodology. A project plan was initiated and established to demonstrate a clear plan of action for improving care in Lanarkshire. This project had an identified timeline of 12 months to deliver the objectives already identified. The plan identified key milestones to be achieved and these were divided into phases to allow these to be achieved within the time scale. This included:

Phase 1 JUNE 2012 Scoping and baseline data collection.

This exercise established the baseline data with regard to the number of ACP plans in use in Care Homes in Lanarkshire at the time (APPENDIX 1). This data included the previous Care Homes involved in the Lanarkshire ACP pilot in 2010. Data collection was obtained by visiting various Care Homes in Lanarkshire and discussing ACP documentation recorded and also by telephone contact to managers and staff. All ACP information and feedback from Care Homes was recorded on an audit database. All information and data analysis during the duration of the project was shared with the Project Lead, Clinical Governance and at ACP Steering Group meetings (APPENDIX 4). This enabled each phase of project development to be clearly focused and effectively delivered in that period. This also included any data analysis to be reviewed, discussed and become a prerequisite for each phase of project activity to ensure successful progress.

Data analysis and feedback from staff – Phase 1

Number of ACPs in Place June 2012 in Care Homes in Lanarkshire by Area
North-East (n) 0
North-West (n) 2
South-East (n) 56
South-West (n) 2

Comments and feedback from Care Home staff during Phase 1.

“We need further education, advice and training on ACP. We did not continue with ACP as we did not receive ongoing support in this area”

“Our residents and carers are happy with our own care plans. We do have some anticipatory care information included in the paperwork; however this is not shared with others. Why is this needed?”

“Our GP Practice is not aware of ACP – why are they not informed?”

Phase 2 SEPTEMBER 2012

Report on previous pilot project and current status of ACP activity in Lanarkshire Care Homes (APPENDIX 1).

ACP Project Steering group was established to inform and direct the project planning within the identified timescale. This working group was responsible for defining and agreeing the aims and objectives required to successfully and efficiently achieving the goals outlined.

The ACP Project Steering Group contributed and reviewed all data collection and at each stage directed the delivery and implementation of the project.

The group ensured best practice strategies and efficiency methodology was incorporated in all major decisions with regard to the project.
Close links were established with Information Services to enable joint working to take place during this project. This was to improve electronic data capture and sharing of key information recorded within ACP. This also allowed monitoring of ACP uptake within Lanarkshire and ongoing activity levels.

Phase 3 SEPTEMBER/OCTOBER 2012 onwards

A Care Home Champions training package was developed to raise ACP awareness, inform and educate staff on the benefits to achieving person centred care. The training was devised based on baseline information given which highlighted challenges to implementation, and gave evidence to devising a collaborative approach to learning. Feedback included:

“Staff do not feel confident to discuss and initiate ACP due to lack of understanding by themselves and Care Home management”.

“Regular changes in Care Home with manager/staff make implementation of change difficult to sustain. We need to be shown how to adopt ACP into our work environment to enable and sustain change”.

“ACP is not discussed or encouraged by GP at resident’s review”.

“Red Flag pages are confusing for staff/carers and not easy to understand”.

“Carer/family resistance to ACP due to lack of information and understanding”.

“We feel there has not been any continued support for staff with regard to ACP since the pilot in 2010 and staff have not kept up with this activity”.

(Examples of baseline feedback from Care Homes in Lanarkshire. June 2012)

The ACP Champions training involved facilitating the background and educational support to providing best anticipatory care planning methods. This included highlighting the benefits to the person involved in the ACP, the carers and to the staff providing care.

This also included an in depth discussion with regard to the ACP documentation and the information leaflets for individuals and carers. This allowed staff to raise and discuss any potential concerns and explore the best methods towards successful implementation in practice.

Another reason for the sessions was to facilitate an environment in the work setting where planning ahead for any future changes to health was considered the norm. ACP should be developed over time and always at the stages that the person and carers involved wish. ACP is a voluntary process and all decisions regarding personal choice must be respected and upheld where possible.

Based on feedback, practical changes were also made to the ACP document to enable the document to be less “confusing” and more user friendly. The Red Flag pages were amended with the inclusion of Symptom and Management areas to enable self management of long term health condition to be recorded.

During the training sessions staff were also advised to report ACP uptake within their workplace. This included the number of ACP’s declined by resident/carer and reasons residents declined. Staff were also
invited to provide comments or suggestions with regard to implementation in their workplace. Feedback from staff enabled relevant support and guidance to be given to improve practice and uptake.

An ACP audit was commenced to capture monthly data collection from Care Homes that engaged with this project (APPENDIX 2 monthly audit form). The audit was devised for ease of completion by managers and staff and not to be overwhelming over other demands in the workplace. Staff were informed that they would be asked for monthly ACP audit returns by email/survey or postal methods.

All ACP Champions were provided with a resource pack with essential ACP guidelines, documentation and helpful hints towards good practice. The resource pack included educational information which was included in the pilot in 2010 as this was a valuable source of information for all staff including those who had previous ACP experience. This also allowed the project to acknowledge and include the good practice aims contained in the 2010 pilot and embed into current practice.

Training sessions were set up at various locations in Lanarkshire to allow best use of staff time, resource and availability. These included various NHSL sites depending on availability and within Care Home settings. On all occasions staff from all Care Homes were invited to engage in training at venues/dates which best suited their needs and travel options.

“ACP is recognition of empowerment for all our residents. We need to ensure choices and preferences are recognised”

May Robertson. Care Home Manager, Netherton Care Home. Lanarkshire.

Activity at end of Phase Three November 2012
<table>
<thead>
<tr>
<th>Area</th>
<th>Baseline</th>
<th>Oct '12</th>
<th>Nov '12</th>
</tr>
</thead>
<tbody>
<tr>
<td>North-East</td>
<td>0</td>
<td>7</td>
<td>21</td>
</tr>
<tr>
<td>North-West</td>
<td>2</td>
<td>13</td>
<td>25</td>
</tr>
<tr>
<td>South-East</td>
<td>56</td>
<td>73</td>
<td>108</td>
</tr>
<tr>
<td>South-West</td>
<td>2</td>
<td>36</td>
<td>77</td>
</tr>
</tbody>
</table>

Data analysis demonstrated an improvement in ACP usage by Care Homes during this period of engagement with Care Home staff and carers.

“ACP is being cascaded in our home. Staff are being educated and ACP is discussed with all new admissions”.

Feedback from ACP questionnaire. Care Home Manager South Lanarkshire.

Phase 4 NOVEMBER 2012 – MARCH 2013

During this phase the aims and objectives of the project were focused on embedding anticipatory care within the Care Homes in Lanarkshire. Challenges or barriers to ACP implementation identified by managers and staff were discussed by staff and project manager and improvement methods were utilised. An example of this is detailed below:

ACP audit return highlighted staff were experiencing difficulty with carers compliance with implementing ACP in the Home. Carers were unsure regarding their role in taking part with ACP as some Care Homes already had personal care plans in place. The Care Home manager suggested that it would be beneficial if the ACP project manager attended the next residents’ carers meeting to discuss ACP and alleviate general concern and uncertainty. This was agreed and delivered to the Care Home as requested. The information sharing session allowed carers to voice their concerns and fears with regard to ACP for their relatives. Questions rose such as “does this mean that my father will not receive quality treatment if he is admitted to hospital because he has an ACP?” Also “why do we need yet more paperwork when all the information is in their personal care plans?” The benefits of ACP were discussed and how this would enhance person...
centred care for their relatives with their support and assistance. Improving communication between staff, resident and carer to enable a better understanding to personal choice and preferences was discussed at length. More importantly, how an ACP provides key information to all staff or carers who are involved in person centred care and a method to improving information sharing.

Carers were advised to revisit the ACP information leaflets and documentation. They were advised to contact the ACP Champions in the Care Home or ACP project manager with regards to any concerns to implementation and use in the Care Home.

The outcome from this session proved beneficial to ACP implementation in this Care Home.

Subsequent ACP audit returns from the home showed a gradual increase in uptake as concerns were addressed and alleviated. Increased participation and uptake occurred as a direct result of providing relevant information, support and guidance to better care. More importantly it was provided at the relevant time to enable further progress of activity.

Similar requests were also made from other Care Homes and information sharing sessions were delivered and have shown to be conducive to increased ACP activity in the Care Home.

Data analysis and feedback from staff - Phase 4

“ACP is a valuable document when engaged appropriately”

Comment from Care Home Champion following training session

To encourage progress of activity and underpin ACP in practice the Champions training was undertaken in 3 relevant sessions. These being:

- **Part 1:** 2 hour education and information sharing session. This included visual presentations to the background of ACP. The session also included a detailed review of the ACP document and information leaflet and how to initiate discussions with residents and carers – when is the right time to discuss? Staff were actively encouraged to ask questions and be involved throughout. Mock scenarios were discussed and also how staff would overcome any challenges or barriers to implementation. Staff were advised that the ACP document must be regularly reviewed to represent and record any changes in health and more importantly discussed with the GP at review meetings. It was also highlighted during these sessions that the ACP document must accompany a resident if and when they were to require acute admission for treatment. This would enable all who are involved in the resident’s care to be informed and any actions to be taken accordingly if possible. Thereby respecting personal choice and enabling decisions to be made to enhance person centred care.

- **Part 2:** Staff were invited to an information sharing session held at Kirklands. The aim of this session was to provide the Champions with the opportunity to engage with wider NHSL staff
and network with other Champions. Relevant speakers from NHSL were invited to discuss their roles and support of ACP and answer any questions that arose from the session. The topics discussed were: Anticipatory medication and management, capacity and Adults With Incapacity (AWI), role of the Champion and the role of Care Home Education Facilitators. This session allowed the Champions to discuss and share their experiences, challenges and good practice methods. It also helped to enhance their confidence with future ACP practice in their work settings. Staff took part in completing an evaluation form (APPENDIX 3 EVALUATION REPORT FROM DECEMBER 2012). They were also asked to complete current ACP audit data for their Care Homes. Positive feedback was shown in the evaluation returns and more importantly a better understanding of ACP was highlighted.

Part 3: All Champions were invited to this session. As before relevant NHSL speakers were invited to discuss their support for ACP and take part in discussions. This session also included a good news story from 3 ACP Champions who had made good progress in their Care Home and initiated change. The main topics of discussion were the benefits of effective communication, a focus on ACP good news stories in Care Home settings and within Community District Nursing and issues with capacity and AWI. These were revisited due to numerous staff requests and also to inform new Champions. The session also enabled NHSL to praise and congratulate Care Home staff for their hard work and efforts with embedding ACP practice in their workplace. Staff were given the opportunity to take part in a photograph session to publicise and acknowledge their roles and activity in Care Homes in Lanarkshire. Staff also received their certificates of ACP Champions training.

ACP Champions Information sharing session. Picture shows 3 Care Home Champions (Croftbank House Ltd Uddingston) who have successfully embedded ACP Practice in their Care home.

During phase 3 and 4 ACP awareness sessions were also offered and given to wider areas in Lanarkshire. These included:
• District Nursing teams in Lanarkshire.

• Carer Groups and organisations (acute and voluntary sector). This included Carer Coordinators/discharge Coordinators in acute sites.

• Specialist Nurses in Acute and Community settings e.g. OPAC nurses.

• Display and information sessions at various events to promote ACP and encourage information sharing e.g. UWS.

“The ACP awareness sessions were informative. We thought that it gave us a better understanding of ACP’s and one colleague believed that there is more to be done in this area.”

Collective comment and feedback from Carer Coordinators and Carer support teams. Lanarkshire.

Jean Neilson completing her ACP with support from Equals Advocacy Partnership

(Picture kindly provided by Equals Advocacy Partnership)

“Completing my ACP means I am in control and allows me to plan for the future” Jean Neilson.

“Equals Advocacy Partnership will assist service users to complete ACP care plans as it gives people dignity, respect and ownership of their treatment” Equals Advocacy Partnership.

ACP Activity. Baseline to Feb 2013

<table>
<thead>
<tr>
<th>Area</th>
<th>Baseline</th>
<th>Oct ’12</th>
<th>Nov ’12</th>
<th>Dec ’12</th>
<th>Jan ’13</th>
<th>Feb ’13</th>
</tr>
</thead>
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SHEILA STEEL ACP EVALUATION REPORT v1.0 MAY 2012-MAY 2013
All efforts were made to provide a learning collaborative approach with all staff to ensure a comprehensive understanding of the key principles outlined in ACP. Staff were asked what challenges and possible barriers they had encountered in the past and how they could overcome these constraints in their work settings. More so relevant measures to implement and embed ACP in practice were discussed and initiated. Staff were encouraged to report all activity to the project manager on a monthly basis.

**Phases 5 and 6 March - May 2013**

These phases of the project reflected a continuation of ACP training and awareness sessions in Lanarkshire. Demand for the sessions for staff increased due to the forthcoming inclusion of ACP in the new GP contract in April 2013. More importantly ACP widely became recognised as best practice in providing person centred care. Managers and staff who were previously hesitant to engage with the offered training were requesting appropriate ACP training to update their skills and knowledge. Training was arranged and provided for all new staff. Support and guidance remained ongoing to all other staff involved with implementing and embedding ACP practice into their care setting.

Data collection of ACP activity and use in the Care Homes remained ongoing. Care Home managers were encouraged to continue with their monthly ACP returns to ensure an accurate representation of activity on the audit data base.

Information Services were involved in all phases of the ACP Project. Measures to collect all relevant ACP data and report for sharing purposes were established and in process. Changes to improve relevant electronic recording and sharing of such data on NHSL e- systems remained ongoing throughout this project.
All stages of the project activity were reported and shared at regular ACP Project Steering Group meetings. The use of ACPs within the Care Homes continued to improve within Lanarkshire as a result of these activities and can be seen in the graph below.

**ACP Usage in Lanarkshire Care Homes Baseline to end of May 2013**

![Graph showing ACP usage in Lanarkshire Care Homes from baseline to end of May 2013.](image)

Whilst the increase in usage of ACPs is very encouraging the uptake has varied in the different areas of Lanarkshire as illustrated in the graph below.

![Graph showing ACP usage in different areas of Lanarkshire from baseline to end of May 2013.](image)

This demonstrates that whilst uptake is increasing there is further work to be done to continue to embed and enhance ACP usage within Lanarkshire as a whole. The data though will be helpful to plan targeting of resource to areas where uptake has not yet been fully established. The data analysis also shows that out of all the Care Homes in Lanarkshire 21 have still to adopt ACPs into practice just over 25%. These Care Homes are evenly split between North and South Lanarkshire, 10 and 11 Homes respectively. Further
work with these Care Homes will continue to increase the overall usage within Lanarkshire and will address a gap for current Care Home residents within Lanarkshire.

“I feel I have the confidence now to start ACP discussions with residents and their families, and also that I am better prepared for any questions that they may have with regards to care.”

“The Champions are helping other staff in the Home with ACP information and initiating the conversation at the right time.”

Comments from ACP Champions at follow up support visits to Care Homes.

District Nurses and student nurses discussing ACP documentation. District Nursing team. Cumbernauld.
Conclusion

NHS Lanarkshire is taking positive steps towards improving and sustaining health care and service delivery to individuals with a long term health condition. This project demonstrated through the various phases and process, clear evidence that anticipatory care measures are key to person centred care. Lanarkshire aims to be forefront in improving care and service provision to its population and above all show respect and compassion to its patients. Therefore proactive measures such as ACP are essential to ensure these measures are safe, effective and person centred.

People are living longer and there is an expected forecast of a 50% rise in the number of over 65’s and double over 85’s between 2010 – 2030 (Office for National Statistics 2013) Early methods of appropriate intervention must be demonstrated now to prepare for and manage the increase in long term health conditions that come with an ageing society. NHS Lanarkshire’s current and future models of care must include and support active management of long term conditions. Thereby enabling individuals and their carers to have a choice in care provision and support individuals to live in their preferred environment whenever possible. This ensures that individuals and their carers have a voice in their future care needs and indeed will help to support NHS Lanarkshire’s service development for the future.

Anticipatory care planning along with more coordinated and integrated care and support at home can facilitate the aims of the Reshaping Care for Older People programme. Through early identification of people with complex health needs and subsequent management with appropriate interventions, the anticipated impact is to reduce exacerbation of condition. Thereby reducing avoidable acute admissions, length of stay for those admitted with an ACP and enabling effective discharge.

This project is cognisant of the key issues outlined in Lanarkshire’s corporate objectives for 2013/14. The main aims being:

- Creating a quality culture characterised by safe, effective and person centred services on all occasions;
- Reducing health inequalities and improving health and healthy life expectancy;
- Integrated health and social care working to support people to live independently at home;
- Avoiding admissions where possible and hospital day cases to be the norm,
- Improving palliative care and supported end of life services;
- Ensuring efficient and effective use of resources and maintaining financial sustainability.
- ACP should be introduced at an early stage to allow discussion, alleviate fears or concerns and enable a positive impact on person centred care.

The findings from this ACP project evaluation highlight that to deliver effective change there is a need for cultural change to be embedded. This includes influencing a change in individuals own perception to health needs and expectations which in turn enable behavioural change.

The focus of Anticipatory Care must always be to respect individual choice and preference. Empowering individuals with the required information, advice and support to manage their own health needs can help
to shift the balance of care in Lanarkshire whilst addressing current and future health needs of the population.

Currently in NHS Lanarkshire these measures are being implemented through its core objectives and aims for models of care. There is a robust focus to plan for anticipated societal and economic influences to be reflected in knowledge and practice and thus maintain sustainability over the coming years. NHS Lanarkshire is taking the lead, in partnership with North and South Lanarkshire Councils, in prioritising and integrating health and social care in conjunction with changes to models of care delivery for its population in later life. Improving our future care, whilst optimising available resource, is imperative to the way forward for achieving better health care.

The Project has clearly identified that there is an appetite to adopt change and embrace ACP into practice when the benefits of ACP are fully understood and appreciated by health professionals, patients and their carers. Significant progress has been made as has been demonstrated in the increased uptake of ACPs within Care Homes across Lanarkshire. Notwithstanding this progress, more work is required to fully embed ACP across primary care, secondary care and within the wider health and social care setting to fully realise the benefits of ACP across Lanarkshire. This will require committed leadership to champion the implementation of ACP and enable adequate resource to provide practical support in the areas identified, covering training, awareness raising, data management and advice and guidance.

**Recommendations**
The outcomes of this project should be used as evidence to support the investment made by the Reshaping Care for Older People South CHP Business Group.

Following the review of evidence detailed in this evaluation the Project Steering Group propose the following recommendations to further enhance embed and sustain ACP knowledge and practice within Lanarkshire:

1. An ACP team should be established to implement and embed ACPs into daily professional practice across primary and secondary care and the wider health and social care setting.

2. The ACP team will be focused on delivering expert knowledge and advice to support health and social care providers. The ACP team will deliver relevant training and awareness sessions to service users and providers to enable ACP practice to be considered the norm throughout Lanarkshire.

3. Roll out focused work with GP’s to establish and embed ACP in General Practice and with practice population.

4. Improve communication channels between all care providers who are involved in the patient care pathway. This will encourage improved ACP participation, compliance with care provision and enhance person centred care.

5. Supporting e health systems and related infrastructure in primary and secondary care to enhance the availability of appropriate information for care providers, whilst contributing to care integration and supporting people with long term conditions. Systems such as:

   - KIS (Key Information Summary). This is a summary of medical history and patient wishes between GP Practices and Out of Hours Service (OOH). This will include elements from the electronic Palliative Summary (e PCS) and include Anticipatory Care forms for patients with Long Term conditions and other relevant information as required.
   - Emergency Care Summary (ECS). This includes key information on demographics, medications and adverse reactions. Relevant ACP information will be included in this summary.

   Improvement measures in these areas include:
   - Support for patients with Anticipatory Care Plans (e ACP)
   - Support for patients with Long Term conditions
   - Support for patients with mental health issues
   - Support for patients with memory loss

Within the scope of ACP these measures will benefit:
   - Individuals with Long Term conditions, in particular if they take multiple medications
   - Individuals who rely on a carer or family member for help at home
   - Individuals who may need care at the weekend or out of hours
   - Individuals who may find it difficult to give details in an emergency

6. Continue the aims within Primary and Secondary Care settings to encourage ACP at all levels, including focused work with General Practices.

7. Incorporate ACP theory and practice in future student nursing and induction learning programmes within NHSL and wider care settings. Future health care must include relevant ACP knowledge and
skills to embed shared decision making and contribute to quality of care.

8. Further focused ACP support and guidance to areas where there has been slow progress as highlighted in the data analysis, whilst maintaining support in other areas.

9. Promote wider ACP communication to dispel fears and uncertainty which may hinder future activity and progress. This may take the form of service user/provider information sessions, display tables within various settings (NHSL and private sectors) and relevant awareness information.

10. Continue evaluation of ACP activity and progress to evidence changes in attitudes to relevant professional practice and cultural behaviour towards self management of care.

11. Support future models of care in health and social care that enable collaborative decision making and integrating care to support people with long term conditions. This would contribute towards maximising future efficient working practices, minimising resource waste and improving quality of service.

12. Continue regular ACP information sharing and communicating good practice sessions to embed multidisciplinary and peer support across Lanarkshire and support learning collaborative.

Below is an example of wider public ACP promotion.

Bothwell Dental Care  Raymond Murphy, Principal Dentist and Sadie Burns, Practice Manager.

The Dental Practice is kindly assisting NHS Lanarkshire’s ACP Project by displaying ACP patient information leaflets in the waiting area of their Practice in Bothwell, South Lanarkshire.

Note of Acknowledgement

The ACP Project Manager would like to thank all staff and identified stakeholders involved with this project, for their continued assistance and support with embedding ACP in Lanarkshire. A special thanks to
the Care Home Managers and the ACP Champions for their hard work and dedication to initiate and embed ACP practice in their care settings. Thank you also to our Public Partners, Carer organisations and wider voluntary groups for engaging with ACP awareness and public information sessions and helping with this process of change in Lanarkshire. Further thanks to the ACP Steering Group for their direction and support with the project, Trish McGlynn and the Care Home Liaison Team for their support and assistance during the various phases of the project, Marie Cerinus for her guidance with facilitating Champions training, Marion Reid for her clerical/admin support and Jonathan Campbell for his valued assistance with data analysis and clinical governance. Finally, to Janette Barrie for her guidance and support throughout this project.

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Lanarkshire Workforce Plan 2012/2013. June 2012
Anticipatory Care Planning (ACP) Project June 2012

Author: Sheila Steel

Review of Pilot Care Homes

Current use of NHSL ACP documentation in Care Homes in Lanarkshire.

Base line Data (including Care Homes involved with 2010 ACP pilot) June 2012

**Pilot Home 1** – 2 ACP’S (approx) currently in place. Good working relationship with GP practice. Staff experiencing challenges with completion of ACP’S due to capacity issues with some residents and compliance difficulties with family/carers. Staff would like further education/training with regard to ACP as this would encourage better understanding.

**Pilot Home 2** – 0 ACP’S currently in place. Similarly capacity issues have been identified as being a barrier to complete plans. Again staff would like training/education/ongoing support with regards to ACP, to benefit communication about the plans. Staff also would like ACP’S to have been completed prior to admission to the home e.g. completed by community staff.

**Pilot Home 3** – 25 ACP’S currently in use. Good working relationship with GP practice who encourage ACP use by home. Some residents have capacity issues due to dementia –family assist to complete ACP. GP’s also regularly discuss ACP at review.

**Pilot Home 4** - 0 ACP’s currently in place. Not encouraged to use by GP practice. Believe it is a very beneficial tool for residents/carers/staff. No ongoing support re use following initial implementation in 2010. Reluctance from family/carers in completing the Plans. Possibly due to insufficient understanding of ACP. Would like further ongoing support/training re use.

**Pilot Home 5** – 2 ACP’S currently in place. There has been some reluctance/resistance from family/carers in completing ACP’s due to lack of knowledge/understanding re ACP use. Staff would like ongoing support/training re use to encourage use of plans. Acknowledge ACP’s identify individual’s wishes/beliefs in what/how their care needs should be met.

**Pilot Home 6** – 6 ACP’S (approx) currently in place. Staff have stated that it is a beneficial tool for communication between resident/carer/staff. Staff would welcome any input from ACP project to encourage use and update knowledge. Staff would benefit from ongoing support with ACP

**Pilot Home 7** - 6 ACP’S currently in place. 7 ACP’s in 2011. Good working relationship with GP practice – ACP’s are encouraged at a resident’s 4 week review and discussed in detail at 6 months. Agree it is a valuable tool which details residents/family wishes. Staff would like ongoing support/education to encourage use.

**Pilot Home 8** – 6 ACP’S currently in place. Staff unsure if they have been completed correctly requesting further ACP training/information. Good working relationship with GP Practice ACP’s discussed at review. Staff have stated that their own care plan’s already have some elements of information required in the ACP’s. Staff would like to have ongoing support/education re ACP’S to encourage use. Agree residents/family wishes should be fundamentally acknowledged in practice.
NB: ACP data provided to Project Manager at the time of base line information collection:

- Approximate numbers provided.
- Managers/staff unsure re key information required in ACP. Many Plans incomplete. Key information not recorded due to lack of awareness/knowledge/uncertainty.

**Current Status: Summary**

The main aim of this project is to embed ACP use within practice through the various systems and structures in Lanarkshire for individuals living with a long term condition(s). Primarily to identify individual choice in how their care needs are met. This will facilitate informed use of the Plans and develop better communication and recording of decisions, thereby leading to provision of care based on the needs and preferences of patients and carers (Living and Dying Well NHS Scotland 2008) This can and will only be achieved through a better understanding of ACP and the benefits of having it in place. It will be achieved through education/training and ongoing support to facilitate appropriate use and understanding. This project will incorporate the key strategies which are fundamental to NHS Lanarkshire, these are – quality standards, patient’s rights, professional code of conduct and equity/quality of service provision.

Baseline information gathered through discussions with care home managers/staff has shown agreement in the benefits of ACP. Many homes identified where residents without ACP had been and continue to be admitted to hospital unnecessarily and against the residents wishes – thereby causing great distress to the individual and family/carer/staff concerned with their care. It was agreed, had an agreed ACP been in place these/similar events would not have taken place and reduced anxiety and stress for individuals concerned. Many Care Homes believe they are unable to prevent such incidents from occurring as they do not have the knowledge and skills to appropriately discuss/assist in the completion of ACP’s with residents and their family/carers.

It was also identified that the 9 Care Homes piloted in the initial project in 2010 still agree that ACP’s are beneficial/essential for residents/carers/staff, however, the reasons they were not currently being completed were multi-factorial:

- changes of manager/staff and other changes initiated within the Care Home e.g. standardization of DNACPR Policy/Liverpool Care Pathway
- staff not being confident to discuss ACP due to lack understanding/training
- ACP may not be discussed/encouraged at resident’s review by GP
- Reluctance/resistance from family/carer due to poor understanding – staff have experienced that when the discussion is initiated the feedback from family/carers is that they believe they are assisting in end of life planning.
- Initial support and training had not been continued after the 2010 project and that has had a negative impact on continued ACP use.

All Care Homes involved in the initial project reported that they want to practice ACP use with their residents and ensure it becomes a standard tool to record their residents/family/carers decisions in case something unexpected happens to a resident’s condition(s).

The Care Homes not involved in the initial pilot have expressed similar views and have reported similar challenges to implementation. Again the benefits of standard use of ACP as a means of essential
communication and documentation regarding individual's decisions/wishes were highlighted. They also welcomed further education/training and support regarding appropriate and informed use of the Plans.

The success of this project lies in engaging and networking with all the main stakeholders involved in ACP use within Lanarkshire e.g. care homes, community nurses, GP’s and volunteer agencies. Positive interest has already been shown in areas such as Carers Network teams in North and South Lanarkshire who wish further education/information regarding ACP. This will help facilitate the promotion to the wider public about the benefits of ACP with individuals with long term conditions. This may be achieved by attending and representation at stakeholder events in the coming months.

Interest has also been noted at a recent Authorised Providers Nursing and Residential meeting by South Lanarkshire Council. This meeting also allowed for informed discussion to take place regarding ACP’S and Care Inspectorate who were interested to know more about ACP’S. It was expressed at this meeting that ACP is beneficial to the individual if it is appropriately completed and reviewed. This requires knowledge and education to appropriately complete ACP’s to incorporate best practice.

This project recognises that to deliver effective change there must be proactive cultural change and this must also be the case within professional practice. Only then can change become a beneficial reality to uphold best practice and service delivery.

The focus of Anticipatory Care must always be to anticipate and effectively manage health problems before they occur. There must be a robust system in place including documentation that is acknowledged and accepted by all who are involved in managing and supporting an individual's preferred long term care needs.

The initial findings from the care homes which were not involved in the pilot have shown a very positive response to the aims of the project. All the managers have shown enthusiasm and interest in training and further education with regards to ACP’S. They are in agreement that ACP’S are beneficial towards individual care needs and will reinforce valued wishes and preferences. They are keen for ongoing input and support as necessary as in the past; factors such as staff movement or reduced input from an area of expertise with regard to ACP have had a negative impact on continued use in the Care Home environment.

APPENDIX 2

The Use of Anticipatory Care Plans (ACP) across Lanarkshire Care Homes

Date ___/___/___

Care Home Name __________________________

What is your current number of residents? _______
What number of your current residents have an Anticipatory Care Plan? ________

If you have residents not currently using an Anticipatory Care Plan, what number of these do not have one in place due to the patient, carer or family declining its use? ________

Do you have anticipatory care included in your own care plans?  
☐ Yes  ☐ No

Of your current residents who have an ACP, how many have remained in their preferred place of care due to this being in place? (Prevented an unnecessary hospital admission) ________

Any other comments:

Many thanks for taking the time to complete this questionnaire.

Please return your completed questionnaire to:

Sheila Steel  
Anticipatory Care Planning Project Manager/Nurse  
Law House  
Carluke  
ML8 5ER  
Tel - 01698 377784 mobile-07788646295

e-mail sheila.steel@lanarkshire.scot.nhs.uk

APPENDIX 3

Clinical Quality Service
1. Table of contents

1. Table of contents

2. Were you advised and instructed on how to use an Anticipatory Care Plan

3. Do you feel confident in discussing an ACP with your patients and their family
4. Have you initiated an ACP for any of your patients / How many

5. Has the ACP training raised your awareness of anticipatory care

6. Do you feel having an ACP in place can make a positive difference to patient care

7. Do you feel an ACP enhances the communication between different groups

8. Do you feel there are any barriers to introducing an ACP for any of your patients

9. Additional comments

Questionnaire

2. Were you advised and instructed on how to use an Anticipatory Care Plan?

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3. Do you feel confident in discussing an ACP with your patients and their family?

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4. Have you initiated an ACP for any of your patients?
On average, 8 ACP’s had been initiated per staff participant (of those who answered yes to this question)

5. Has the ACP training you received raised your awareness of anticipatory care?

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6. Do you feel that having an ACP in place can make a positive difference to patient care?

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</table>

7. Do you feel an ACP enhances communication between the following?
Clinic staff and patient (n) | 36
Clinical staff and families (n) | 34
Nurses and doctors (n) | 30
Nursing staff and patient (n) | 46
Nursing staff and families (n) | 41
Communication not enhanced (n) | 0

8. Do you feel there are any barriers to introducing an ACP for any of your patients?

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<tr>
<td>Total (n)</td>
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8.1 If yes, describe them:

Capacity to complete

When resident has poor communication and family have limited communication skills/support

Families/patients are wary of discussing financial questions, especially as it is not seen as an official document

Care plans already in place. GP and Hospitals not getting on board. Families reluctant to discuss

Patients with dementia

Some residents/relatives don't wish for ACP, despite several requests from nursing staff

Clients/families not interested/do not want to make those kinds of decisions at present

All my residents are end stage dementia. Rely on families to help us complete them and some families don't visit that often

Fear / uncomfortable topic

Families not willing to participate

Social work department

Power of attorney

Residents who lack capacity cannot contribute. Relatives do not wish to

I worry hospitals will not return them

9. Additional comments

I think this is a valuable document when engaged appropriately. I think more awareness is needed as champions, this will promote the ACP
Would have liked a filled ACP to understand how to fill it in and more time to do it
Feel it is more the responsibility of community-based staff
Brilliant session - really enjoyed it and learned loads!
Good theory - practice. Pro-active management, not reactive
ACP’s should be introduced to NHS acute care before care homes become more involved
Enjoyed input about capacity. Would attend another capacity session if possible
The use of the Anticipatory Care Plan – Staff Evaluation Questionnaire

This questionnaire relates to your experience of your patients using an Anticipatory Care Plan (ACP). This is an anonymous questionnaire and your answers will be treated in the strictest of confidence. Many thanks.

1. Were you advised and instructed on how to use an Anticipatory Care Plan?
   - Yes  - No

2. Do you feel confident in discussing an ACP with your patients and their family?
   - Yes  - No

3. Have you initiated an ACP for any of your patients?
   - Yes  - No
   3.1 If yes, please tell us how many ______

4. Has the ACP training you received raised your awareness of anticipatory care?
   - Yes  - No  - Unsure

5. Do you feel that having an ACP in place can make a positive difference to patient care?
   - Yes  - No  - Unsure

6. Do you feel an ACP enhances the communication between any of the following? (Please tick all that apply)
   - Between Clinical staff and patient
   - Between Clinical staff and families
   - Between Nurses and Doctors
   - Between Nursing staff and patient
   - Between Nursing staff and families
   - I don’t feel the ACP enhances communication

7. Do you feel there are any barriers to introducing an ACP for any of your patients?
   - Yes  - No
   7.1 If yes, how would you describe them? ____________________________________________

Thank you for taking the time to complete this questionnaire. Please use the space below to add any additional comments.
### ACP Project Steering Group

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
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<tbody>
<tr>
<td>Janette Barrie</td>
<td>Nurse Consultant for Long Term Conditions (Chair)</td>
</tr>
<tr>
<td>Sheila Steel</td>
<td>ACP Project Manager</td>
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<tr>
<td>Angela Campbell</td>
<td>Care Home Liaison MH</td>
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<tr>
<td>Diane Campbell</td>
<td>Patient Safety Manager</td>
</tr>
<tr>
<td>Anita Coia</td>
<td>Service Manager</td>
</tr>
<tr>
<td>Dr Iain Hathorn</td>
<td>Lead GP/Clinical Director</td>
</tr>
<tr>
<td>Marjorie McGinty</td>
<td>Reshaping Care</td>
</tr>
<tr>
<td>Patricia McGlynn</td>
<td>Care Home Liaison Nurse</td>
</tr>
<tr>
<td>Fraser McLellan</td>
<td>Information Services Manager</td>
</tr>
<tr>
<td>Liz McPake</td>
<td>Care Inspectorate</td>
</tr>
<tr>
<td>Pamela Milliken</td>
<td>Head of Clinical Governance</td>
</tr>
<tr>
<td>Judith Milligan</td>
<td>E Health Manager</td>
</tr>
<tr>
<td>Norma Paterson</td>
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<tr>
<td>Lorraine Smith</td>
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