Anticipatory Care Planning

Greater Glasgow & Clyde

Guidance/Standard Operating Procedure

Lead(s):	Kim Campbell, HSCP Unscheduled Care Change & Improvement Manager Jennifer Watt, Anticipatory Care Programme Manager
Developed by:	ACP SLWG
Responsible Director:	Fiona Smith
Approved by:	Quality Oversight Strategy Group
Date approved:	1st February 2022
Date for Review:	March 2023
Replaces:	New GGC SOP
Replaces previous version: [if applicable]	

Alert – Pending Changes
There is due to be an update to the ACP Summary on Clinical Portal which will remove the mandatory consent box. Please see section 7.2 of this document for explanation of this change. Until this change is made, consent should continue to be recorded.

Contents

1. Purpose of this Document

Across GGC there is a wide range of individuals developing ACP; 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

Anticipatory Care Planning (ACP) is a person-centered, 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 ACP 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.

ACP 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 an Anticipatory Care Plan and shared with the people that need to know.

3. Scope (including target population)

3.1. Target Population for ACP

ACPs 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 an Anticipatory Care Planning conversation.

Age should not be a limiting factor when considering whether someone could benefit from an ACP. 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 ACPs appropriate if someone lacks capacity?

If someone lacks capacity, this does not automatically exclude them from having an ACP. 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-centered 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 ACP Summary Document so that it can be shared across multiple services.

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

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 Anticipatory Care Planning and to carry out the ACP 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 ACPs.

To support this Team Leads are advised to:

- Add ACP to team meeting agendas
- Share the number of ACPs 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 11)

4.3. Service Managers

It is the role of Service Managers to monitor ACP activity across of all their areas of responsibility and to report to their HSCP Unscheduled Care Lead/Anchor re progress and to highlight areas needing improvement support or where risk is identified.

4.4. ACP Champions

An ACP Champion works with their colleagues to help promote the use of ACPs, offering advice and information to help empower staff to have these conversations

with the people they work with. They will help promote a positive ACP culture across NHSGGC, working together to give people control over their lives.

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

- Helping to create a positive ACP culture within NHSGGC and HSCP's
- Promote the use of ACPs within the work of the team
- Support members of the team to complete ACPs by offering advice and information on best practice (or directing them to the ACP Team if you are unsure) including training new team member on how to use and record ACPs
- Provide feedback to the ACP Team on behalf of colleagues
- Distribute communication from the ACP Team 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 ACP developments and share these with colleagues

Further information about ACP Champions can be found on the NHSGGC webpages including a role description and how to register to become a champion.

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 ACP plans. This should be shared at their HSCP Unscheduled Care Groups.

The Anchor or their delegate who attends the GGC ACP Design & Implementation Group should raise any issues/concerns regarding the system and processes to support ACP completion, any incidents that occur requiring attention, examples of good practice and provide performance updates.

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 ACP 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 ACP conversations. Guides for the public have been created which outline the DISCUSS topics (See section 7.1).

The public can also be directed to the NHSGGC ACP webpages for further information covering topics such as:

- Anticipatory Care Planning
- Cardiopulmonary Resuscitation (CPR)
- Planning for Unexpected Events
- 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. Initiating the ACP 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 ACP conversations. Guides for the public have been created which outline the DISCUSS topics (See section 7.1).

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.

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 11).

Talking about Care Planning: RED–MAP		
R eady	**Can we talk about your health and care?**	When would be a good time to talk? Who should join us? This about making good plans for your treatment and care.
E xpect	**What do you know?** **What do you want to ask?** **What are you expecting…?**	How have you been doing recently? What has changed? How do you see things going in the next days/ weeks/ months….? **Some people** think about what might happen **if…?** Can we talk about what might happen if you get less well?
D iagnosis	**We know…** **We don't know…** **Questions or worries?**	What is happening with your (*health problem*) is… We **hope** that…, but I am **worried** about… **It is possible** that you might not get better because… We **don't know** exactly when…, can we talk about that? Do you have questions or worries you'd like us to talk about?
M atters	**What matters to you?**	What's **important to you** that we should know about? Are there things **you'd like** or **wouldn't want** for you?
A ctions	**What can help…** **This does not work…**	Things we **can do** are…. **Options** we have are… This **does not work** because…./ **will not help** when/if….
P lan	**Let's plan ahead for when/ if….**	Can we make some plans so everyone knows what to do? Talking and planning ahead **'just in case'** helps people get better care.

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

7. Recording the content of ACP Conversation

7.1. Key topics

ACP 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 are never take place depending on timelines and/or the person's willingness to engage.

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

7.1.1. 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.

7.1.2. 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.

7.1.3. 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.

7.1.4. 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.

7.1.5. 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.

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

7.1.7. 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.

7.2. 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 ACP 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.

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

If a person (or their legal proxy) does not wish for this information to be shared across services, they can refuse and opt out of having an ACP contained within their files. 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.

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

A person may decide not to give permission for ACP 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 an ACP. A note should be made within "Special Notes" section to outline what information can and cannot be shared with certain individuals.

7.3. Discussions where capacity is in question

If capacity is in question please document this in the "special notes" section of the ACP 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.

The Scottish Government have produced guidance for professionals who need to assess capacity.

7.4. Managing Expectations

ACPs are not legally binding. Depending on service capabilities and availability, some treatment or care options may not be possible (e.g. CPR). Similarly, whilst it is helpful to record preferred place of care, 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 ACP Summary. This will allow for greater flexibility within any treatment or care plan whilst still adhering as close as possible to people's preferences.

7.5. Paperwork

There are multiple places and documents which gather information which could be useful within an ACP. 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 an ACP 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 ACP 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 has been created to help staff identify what information can be contained within the ACP Summary document, and where it should be documented.

The ACP 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. Access is also being rolled out to Social Work staff who will be involved in ACP conversations.

For professionals who do not have access to Clinical Portal (e.g. they work in an external organisation such as Care Homes or Carer Support Services) an interactive PDF version of the ACP 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.

7.5.1. Clinical Portal

7.5.1.1. How to set up an account

All clinical staff should have access to Clinical Portal. Access is also being rolled out to Social Work staff who will be involved in ACP conversations.

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 ACP, however will provide staff with a foundational knowledge of how to navigate Clinical Portal.

7.5.1.2. Viewing and Updating the ACP Summary on Clinical Portal

- Guide to updating ACPs on Clinical Portal – PDF
- Guide to updating ACPs on Clinical Portal - Video

If an ACP Summary has already been created, a "read-only" version can be found with the "Care Plans" section of the Clinical Documents tree. All staff an encouraged to check on Clinical Portal to see if the document has been started prior to the initial meeting with the person.

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

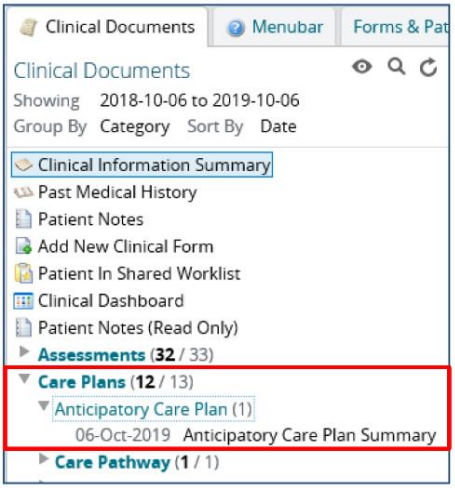

Figure 2. Document Tree on Clinical Portal.

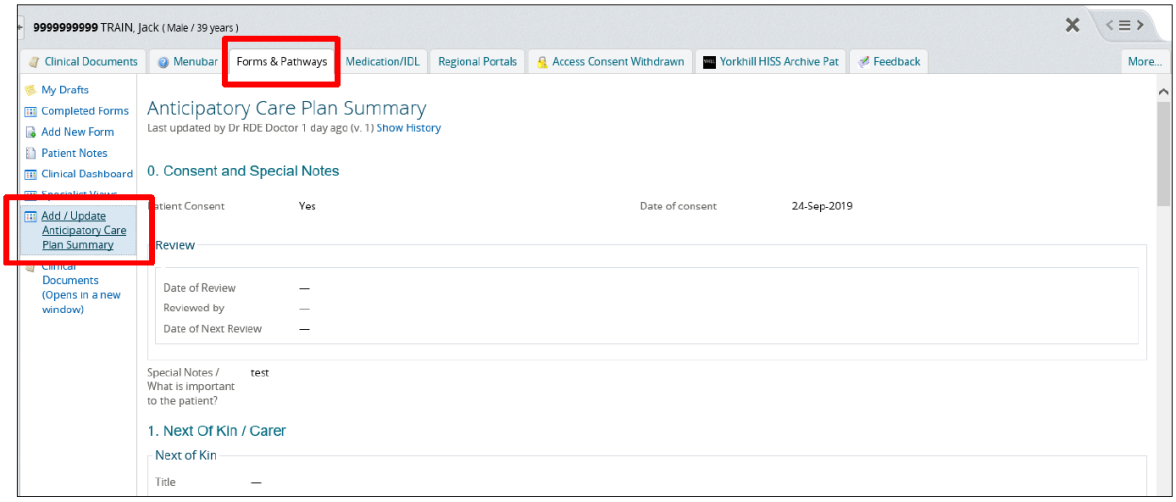

Figure 3. Forms & Pathways tab on Clinical Portal.

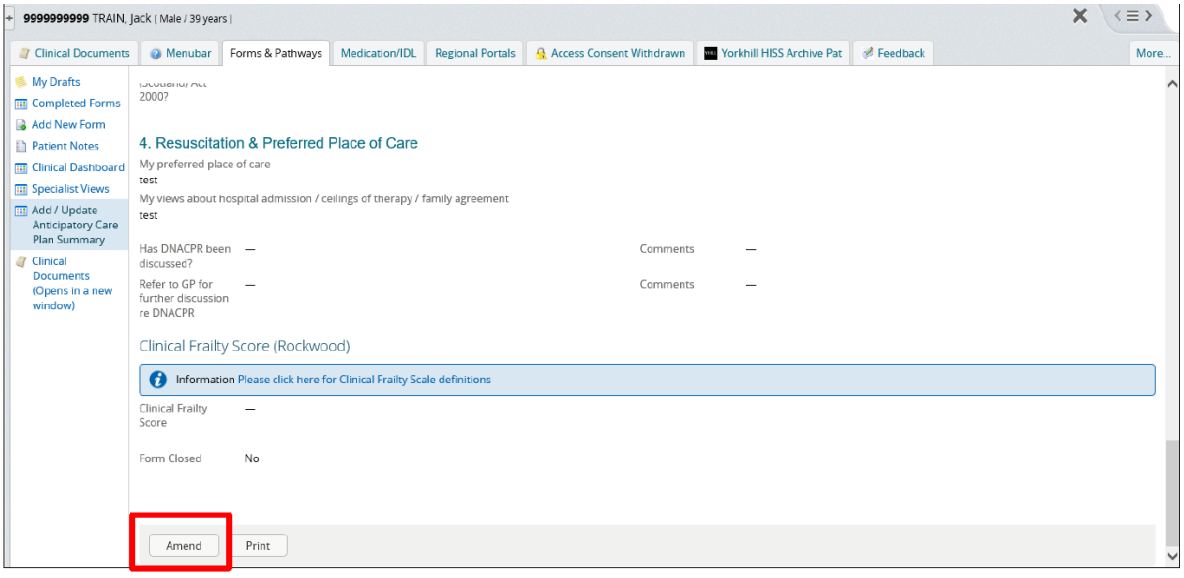

Figure 4. Amend button for ACP Summaries which have previous been created.

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 text boxes.

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

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 ACP Summary. If they wish, the GP Practice Team can then update the person’s Key Information Summary (KIS) to reflect that an an ACP Summary has been created, or to document the information contained within the ACP Summary.

7.6. Transfer to Key Information Summary

7.6.1. 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 ACP Summary contains this information as well. However, unlike KIS, the ACP 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 an ACP 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 an an ACP Summary has been created, or to document the information contained within the ACP Summary.

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

7.6.2. 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 ACP Summary "special notes". See Process Flowchart (Section 14.1).

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

7.6.3. Primary Care

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 ACP Summary has been created.

The ACP 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 ACP 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 should be highlighted to all surgery admin support in order to ensure that members of the GP Practice Team are aware that an ACP Summary has been created.

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

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

Healthcare Improvement Scotland have guidance for GPs and Primary Care staff regarding the use and updating of KIS.

7.6.4. Onward Referrals Including DNAPCR

As part of an ACP 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 for 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.

7.6.4.1. Who to refer to?

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 legal 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 ACP Summary as well in case an emergency arises before the conversation can take place..

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

7.6.4.2. 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 ACP Journey

Whilst it is important to record the detail of ACP conversations in the ACP Summary documentation (either PDF or Clinical Portal), it is also important to record where someone is in their ACP journey, and any progress has been made. This includes

recording when someone is engaged in an overview conversation, the process of completing an ACP Summary and even if/when the ACP is reviewed.

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

8.1. Where is the ACP Journey Recorded?

To assist local HSCPs to record activity and therefore report improvement/progress a spreadsheet is available. Local arrangements will be made to coordinate input and recording of data. If you are unsure as to how you should be recording the ACP journey, speak with your line manager.

8.1.1. Collection of Data for Local Report

Depending on the systems staff already use, there are currently two ways to record the ACP Journey – using EMIS or a locality spreadsheet.

It is also best practice for the commencement and/or completion of an ACP to be incorporated into patient record held by the service.

8.1.1.1. 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.

Team Leads will have responsibility for running EMIS reports every quarter which detail how many of each code has been recorded by their team. This information should then be recorded on the **front sheet** of the Locality Spreadsheet on their individual team’s row.

8.1.1.2. Locality Spreadsheet

For any team which does not use EMIS, staff can record the ACP journey directly onto the Locality Spreadsheet. This will record similar information to EMIS. For each step, staff should input the **date** at which the step was completed.

Each spreadsheet will contain a separate sheet for each individual team within the locality. Staff should only input information to their own team’s sheet.

8.1.2. Storing

The locality spreadsheet should be stored in a location which is accessible to as many teams within the locality as possible. This could be a sharedrive on the local network or a SharePoint site on the local intranet. Individual HSCP will have responsibility for deciding where this information is stored.

8.2. What Steps Are Recorded?

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

Code	Definition	Further context required (EMIS only)
Has anticipatory care plan	ACP already in place from previous time/service	From when?
Anticipatory care plan offered	ACP conversation held with person about what it is, benefits etc.	Patient/Family attitude
Anticipatory care plan declined by patient	Person declines an ACP at this stage	Reason?
Anticipatory care plan completed	ACP 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 ACP Summary*	Have any steps been taken to resolve this?
Review of anticipatory care plan	ACP Summary reviewed	Any update required

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

8.3. Responsibility

8.3.1. HSCP Leads

It is the responsibility of each individual HSCP Lead (Anchor) to liaise with local teams to ensure that the Locality Spreadsheet is stored in an appropriate and accessible location (see section 8.1.1.2).

It is also the responsibility of each individual HSCP Lead to monitor this data collection and report back to the ACP Design & Implementation Group. If issues are identified either in data collection, or team activity, it is their responsibility to work with identified local leads to rectify issues.

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 on the locality spreadsheet. If the team use EMIS this will require running quarterly reports and updating this data on the front sheet of the spreadsheet. If the team does not use EMIS this will require robust data input by individual staff members on the individual team sheet.

Team Leads are responsible for ensuring their own team provide/input all necessary data into the appropriate system (EMIS or Spreadsheet).

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

8.4. Monitoring

HSCPs will monitor their local activity against their plan. The ACP Design & Implementation Group will have oversight across all HSCP areas to monitor ACP activity across the NHSGGC Board Area.

9. Review

The ACP 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 require review period it is best practice to review and revisit ACP 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 ACPs are reviewed when necessary. It is also their responsibility to ensure any updates are recording on the ACP 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. ACPs in Care Homes

The process for commencing an ACP 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. PDF Summary

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

Instead it is proposed that Care Homes can choose to include the PDF version of the ACP 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.)

10.2. Quick-Look Guide

Given the wider variety of care home documents, it may be helpful for Care Homes to have a quick-look guide which will direct staff to where useful information may already be held for residents when they are completing the ACP Summary. If a home

is interested in developing a quick-look guide they should email ACPSupport@ggc.scot.nhs.uk.

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 ACP 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 ACP 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 Anticipatory 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 ACP 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 ACP, 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 ACP notes. If residents do not have an ACP, CHLNs can support Care Home staff to begin creating one.
- CHLNs can assist Care Home staff in sharing ACP information with GPs. This could involve ensuring Care Homes have access to helpful and appropriate paperwork such as the ACP Summary. In some cases this may extend to uploading ACP Summaries to Clinical Portal however this will depend on capacity.

10.5. Training for Care Home Staff (see also Section 11)

General ACP training is available to all Care Home staff. This includes access to the ACP e-module and generic ACP Communication Skills training sessions.

Information for both of these opportunities can be found on the ACP Training Hub on the NHSGGC ACP webpages.

There is ongoing development of specific training for care home staff, including clinical skills training. This is the responsibility of individual HSCPs. It is advised that care home managers contact relevant HSCP contacts to enquire about opportunities for further training within their own areas.

10.6. Good Practice Example for Care Homes

A library of example ACP Summaries has been created which cover a range of various scenario, including an ACP Summary example for a Care Home Resident.

11. Training

11.1. E-Learning

An online learning module has been created to provide all staff with a general understanding of Anticipatory 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:

- ACP Website
- Learnpro – GGC:028 Anticipatory Care Planning

11.2. Communication Skills Training

Anticipatory Care Planning Communication Skills Training can be accessed by any professional via the ACP website. This 2 hour session is delivered via MS Teams.

Bespoke sessions are also being delivered to specific staff groups within each HSCP. Team Leads should contact ACPSupport@ggc.scot.nhs.uk to organise these sessions for their teams.

NHSGGC also deliver RED-MAP and Sage and Thyme training for all staff. These training sessions are facilitated by the NHSGC Palliative Care Team. For further information contact info@palliativecareggc.org.uk

11.3. Other educational resources

Please view the NHSGGC ACP Webpages for more educational resources including a list of other suggest learning opportunities.

12. Quality Assurance

It is important that ACPs 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 ACP Summary. A guide has been created to help staff understand the various topics which could form ACP discussions.

The ACP Summaries stored on Clinical Portal will undergo quality assurance audits to ensure that the information gathered and record is accurate and relevant. This process is currently being discussed by the ACP Design & Implementation Group.

A range of example ACP Summaries have been created to help staff understand what information should be recorded in order to form a robust ACP.

- Care Home Resident
- Person living with cancer
- Person living with dementia
- Person living with COPD
- Person receiving palliative care
- Person at end of life (still to come)
- Carer
- Parent Carer
- Person on the autism spectrum
- Older person living independently (still to come)
- Young person transiting between services (Example CYPAMD also available)

Example ACP Summaries will continue to be added to this library.

13. Supporting Guidance

13.1. Hyperlink index

13.1.1. ACP Champions

Role description
Register to become a champion

13.1.2. ACP Documents and Guidance

PDF version of the ACP Summary
ACP Summary guide
Guide to updating ACPs on Clinical Portal – PDF
Guide to updating ACPs on Clinical Portal - Video
DISCUSS - A Guide For People Thinking About Their Future
DISCUSS - A Guide For Friends, Family and Carers
DISCUSS - A Guide For Staff

13.1.3. Clinical Advisory Network

Register to sign up to the Clinical Advisory Network

13.1.4. Example ACP Summaries

- Care Home Resident
- Person living with cancer
- Person living with dementia
- Person living with COPD
- Person receiving palliative care
- Person at end of life (still to come)
- Carer
- Parent Carer
- Person on the autism spectrum
- Older person living independently (still to come)
- Young person transiting between services (Example CYPAMD also available)

13.1.5. Further Topic Specific Information

Cardiopulmonary Resuscitation (CPR)
Power of Attorney
Shared decision making process
Realistic Medicine
Planning for Unexpected Events
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

13.1.6. Mailing List

Register to join mailing list.

13.1.7. Professional Guidance

Guidance for professionals who need to assess capacity (Scottish Government)
Guidance for GPs and Primary Care staff regarding KIS (Healthcare Improvement Scotland)

13.1.8. Training Links

ACP Training Hub
ACP Emodule
Learnpro
Anticipatory Care Planning Communication Skills Training

RED-MAP
Sage and Thyme
Other suggest learning opportunities

14. Annex:

14.1. Process Flowchart