NHS Lanarkshire

Phase 2 Anticipatory Care Planning in Lanarkshire From Best Practice to Common Practice

Project Evaluation Report March 2015

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Executive Summary

This report provides an analysis and evaluation of work undertaken within the Phase 2 ACP project in Lanarkshire, which ran from May 2013 - March 2015. Building upon the findings and recommendations made in Phase 1, the next steps were to widely establish (and firmly embed in practice) the anticipatory care planning (ACP) process and related skill set.

It presents the approach taken and key metrics achieved during ACP Phase 2. The aim of the project and project outcomes highlight the positive impact of joint working and the strong partnership ethos between care and service providers to benefit patients, service users and their families.

Positive experience and realisation of personal outcomes through the ACP process are demonstrated by the increasing contact, enquiries and steadily increasing ACP activity. The achievements have set a benchmark for similar future care models to incorporate ACP ideology, to positively influence and sustain behavioural and cultural change to support people with long-term health issues.

One of the key aims of the ACP process is to make substantial changes to the way individuals and care providers think about an individual's health and well being. This may include discussing collaboratively their personal goals and wishes, and to record these decisions so that in the event of a gradual or sudden decline, those providing care have explicit guidance on what the person would wish to happen. The ACP process also provides the opportunity to support self management of symptoms, facilitating independence for as long as possible.

Many older people live with multiple chronic or complex conditions. It is essential that a proactive and forward-thinking approach is adopted and relevant steps are put in place to ensure that models of care are designed to meet the many needs of individuals. ACP facilitates a whole-systems approach for people living with long-term conditions, it ensures person-centred care and that personal outcomes are achieved. **(Scottish Government May 2010)**[1]

Thinking ahead and planning for future care (or potential health changes) is a topic that many people (including many healthcare practitioners) may find difficult to discuss or initiate within conversations. This was highlighted through feedback from patients, carers and staff following ACP training sessions. However, this is a very important first step and at times, may be an opportunistic ACP trigger during trusted therapeutic encounters and conversations.

The core aims and objectives of ACP Phase 2 were to strengthen and enhance the process of learning from Phase 1, to build upon this experience and support NHS Lanarkshire and other agencies to accept ACP as fundamental in care, and as an example of excellent proactive practice.

1 **The Healthcare Quality Strategy For Nhs Scotland. The Scottish Government May 2010**

ACP requires cultural and behavioral change: processes that take time and patience to fully embed in practice. This work has shown that ACP has a role to play in all health and social care services for people with long term-conditions within Lanarkshire, with potential benefits such as:

- Better health related-quality of-life for those with complex or long-term conditions;
- Reductions in potentially avoidable acute hospital admissions and length of stay;
- Reductions in service use and resource impact (acute/primary care);
- Enabling more people to remain independent in their own homes for as long as possible, with appropriate self-management strategies and relevant support;
- Improved communication of key person-centred information.

To demonstrate the impact of this project we collected key metrics from a number of sources. Following analysis, our findings show:

- **56%** of Lanarkshire Care Home residents (from 87 Care Homes) had an active ACP in place by March 2015;
- **15,383** ACP/eKIS[2] Key information available to share by March 2015;
- **85** Care Homes implementing and embedding ACP within their work setting;
- **264** Care Home staff received ACP training (North Lanarkshire Care Homes);
- **484** Care Home staff received ACP training (South Lanarkshire Care Homes);
- **431** Care Home residents with an active ACP remained in their preferred place of care following a change in health
    - This equates to **£754,250** estimated cost savings in one year;
- **970** NHS Lanarkshire staff attended ACP awareness sessions.

Recommendations:

- To continue supporting health and social care staff to firmly embed ACP into the culture of health and social care delivery, keeping the person central to all elements of care;
- To incorporate and connect with other work streams that support ACP;
- To take every opportunity to include ACP in undergraduate and postgraduate education;
- To continue to raise awareness within the general public;
- Support a further phase of the ACP work.

2 ekis, Electronic Key Information Summary

Background

The essence of ACP is to help people with long-term conditions to have the confidence, control and choice that comes with knowing what might happen, spotting small indications of change and being ready to do the right things with the right support from the right people. ACP should be tailored to the stage of the patient's condition, and as such, exemplify person-centred, holistic care.

Rising demand on healthcare systems from individuals with complex and long-term conditions, means that care models will need to change if they are to effectively continue to provide high-quality services to all who need them. This challenge is made more acute by tight financial budgets and related constraints; however there is a necessity for a priority approach to address population health needs. There are many ways to respond, however; this report considers one such response, in that to sustain quality care requires focused activity with the relevant dedicated support over a period of time, to ensure the process is understood and firmly embedded in practice. Only then can individuals and carers with the right knowledge and skills become empowered to have better control, regarding their own health and well being.

With an expected increase in the number of people living with a long-term health condition, there needs to be radical change to current models of care to support effected individuals so that they have greater knowledge, empowerment and expertise in the daily management of their condition. NHS Lanarkshire fully recognises this need for change, and alongside the aims and objectives for Reshaping Care for Older People, has incorporated the necessary steps to improve the process of 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)**[3]

NHS Lanarkshire has taken a proactive approach by implementing a programme of work to embed the use of ACP with individuals. The intention is to offer every patient with a long- term condition an ACP, which can range from a self-management plan through to end-of-life care. This will empower individuals and carers to identify early, any circumstances that may have a negative or detrimental impact on their health and wellbeing, and on their long-term condition. Consequently, this process will enable meaningful discussion and relevant recording of future healthcare wishes and preferences before any deterioration of health. ACPs provide the individual with an opportunity to make informed choices about their own health and wellbeing, and discuss any concerns with those close to them or involved in their care. The process involves recording the individual's preferred place of care and preferred wishes for end-of-life care.

ACP is consistent with strategies outlined in **A Healthier Future**[4]**, 20:20 Vision**[5] and **The NHS Scotland Quality Ambitions**, all of which recognise the need for "working with people to ensure shared responsibility for prevention, anticipation and self management."

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3 **Living and Dying Well: Building on Progress. The Scottish Government 2011**

4 **A Healthier Future. A Framework for NHS Lanarkshire. Strategic Planning 2012- 2020**

5 **20:20 Vision - The Scottish Government www.scot/Topics/Health/Policy/2020-Vision**

"Completing an ACP is like a wakeup call... to take ownership of my own health and inform others with regard to my wishes/choices"

Service user's comments following Patient Advocacy support with ACP process

The process facilitates discussions between practitioners and relevant individuals / carers, to look at collectively managing a further detriment to personal health, by working with individuals to help them adopt a "thinking ahead" approach, and to have greater control in the event of a flare up of their condition or a carer crisis.

ACP can help empower individuals to be aware of their own health needs and choices in care: a process which is encouraged and enhanced through relevant discussions with health or care providers. It is a person-centred process that helps to provide individuals and carers with the knowledge and skills they need to understand their condition, early indications of change and the effects on their general health and wellbeing. ACP can support individuals and carers to make decisions that are important to them, and to become more involved in planning and decision-making about their treatment and care. At times this may involve deeper and sensitive discussions with regard to how early indications of health needs can be effectively managed, including how their condition may progress over time. Establishing this aspect within any ACP discussion can help individuals and carers develop the confidence to take more responsibility and control over their own condition and care.

"Patients who have completed an ACP with their family, have done so in the knowledge that their wishes are valued and respected by all care providers"

Comment from a Community District Nurse following ACP discussions with a patient and carer

Project Definition

- To embed and sustain the ACP process and use within Lanarkshire for all individuals living with complex or long-term condition(s);
- To identify and record within ACP care plans, individual choice in how their care needs are met;
- To promote eKIS, the electronic key information summary where ACP information is in electronic format and accessible to relevant care providers including community and primary care services, Scottish Ambulance Service, NHS 24, Out of Hours services and the acute sector
- This allows better communication or recording of personal decisions, leading to provision of care based on needs and preferences of patients and carers **(Living and Dying Well NHS Scotland 2011)**

Below are key areas included in all ACP facilitator education and training sessions:

ACP can support individuals and carers to make decisions that are important to them and encourage the individual in your care to become more involved in planning and decision-making about their treatment and care

If these discussions take place at the right time (or relevant window of opportunity to initiate the conversation) and the right place (home visit or clinic setting), it can help people to recognise early signs and symptoms of condition change and relevant effective management that may reduce or prevent crisis at a later stage.

Establishing this aspect within any ACP discussions can help individuals and carers develop a better understanding of the process and enhance personal confidence to take more responsibility and control over their own condition and care.

Aims And Objectives

Core aims and objectives of ACP Phase 2 were underpinned by the activity and performance outcomes during Phase1, and subsequent recommendations for further work to enhance and sustain quality person centred-care in Lanarkshire.

Project Aims

- Promote and increase ACP across health, social care and voluntary sectors to ensure that patient preferences for place of care and end-of-life care are respected;
- Test, implement and spread how the ACP is used with the acute environment and follows the patient through an unscheduled admission;
- Promote the use of the electronic system for ACP sharing through eKIS implementation;
- Support other admission avoidance activity within Lanarkshire.

Core Objectives

- Build on work already undertaken in Lanarkshire Care Homes to spread the uptake and use of NHS Lanarkshire ACPs;
- Continue to spread ACP awareness and use through Primary Care and Community District Nursing services, with particular emphasis within palliative care and patients with complex needs;
- Ensure that existing and future ACP documentation is complete, up-to-date with relevant health information including relevant DNACPR[6] information and regular review (as required) of condition and health change and needs:
  - This ensures that existing ACP records reflect personal choice and appropriate completion of "red flag/self management" areas;
- Use available technology to ensure that ACP sharing is available to share at the point of need e.g. eKIS;
- Implement a programme of transference of existing paper-based ACP key information to the available electronic system;
- Implement a test of change using a minimum of three clinical areas (Care Home, primary care, acute setting), to test how an ACP can follow the patient to, and where necessary, through, one acute site;
- Identify staff training needs, develop a teaching/learning resource and undertake in- depth facilitation of relevant staff across the three District General Hospital sites in Lanarkshire;
- Support General Practitioners and Practice Managers in implementing the ACP QoF[7] indicators.

"The provision of ACP information and guidance at Stakeholder events is ideal to provide education and relevant Information to individuals and their carers. Motivating people to be actively involved in their health and wellbeing, the importance of thinking ahead and giving them information to help them understand and manage their condition – common sense really"

Comment from Carers' Network group

6 DNACPR, Do Not Attempt Cardiopulmonary Resuscitation
7 QoF, Quality Outcomes Framework

Project Approach and Methodology

The approach reflected that used in the preliminary phase 1 of the project to embed ACP usage within Lanarkshire. This included:

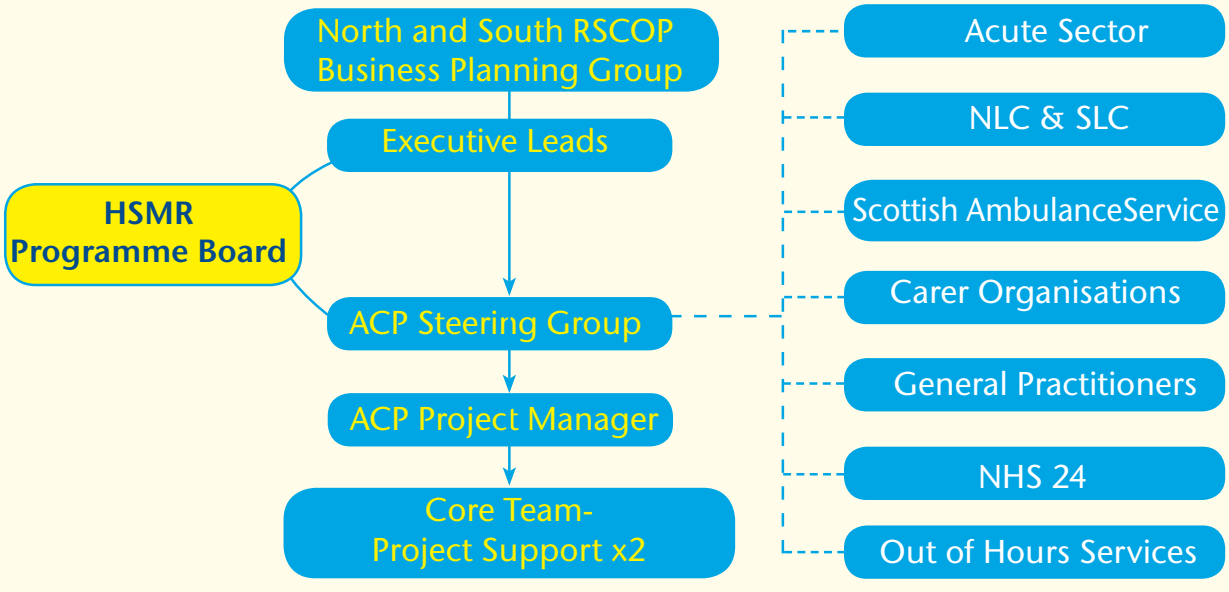
- Focused leadership of Phase 2 activity through recognised project management methodology;
- Partnership with relevant stakeholders e.g. Community District Nurses, Clinical Leads, Acute Hospital, Care Home and Voluntary Sector Organisations;
- Structured approach of review and discussion with community nursing teams, with regard to current use of ACP;
- Structured approach of review and discussion with General Practices to ascertain current understanding/involvement with regard to ACP and support implementation of the ACP QOF indicator;
- Targeted approach using cascade training, thereby training identified staff from each Care Home, community, voluntary and acute site areas as ACP Champions or Link persons, to implement ACP within their own area.

"Completing an ACP with individuals and their loved ones is recognition of empowerment for all our residents. We as care providers need to ensure individual choices and preferences are recognised and respected when discussing ACP"

Care Home manager. South Lanarkshire

Stakeholder Engagement

Figure 1: Phase 2 organisation of identified stakeholders



Test Of Change Methodology

The test of change included the identification of a minimum of three clinical settings in one locality (e.g. primary care, Care Home and acute hospital), and involved in-depth facilitation of staff within these areas, in respect of ACP awareness and use of the relevant information to manage changes in health needs, and reduce crisis situations. This included tracking how an ACP follows the patient during the journey in, through, and out of the identified acute setting. This involved a small cohort of individuals with a history of regular acute admissions from Care Homes and District Nursing services within the chosen locality. This process identified opportunities for individuals and care providers to discuss proactive interventions at an earlier stage, and capture personal goals or wishes within the ACP.

Quality Ambitions

The project was consistent with the three Quality Ambitions for NHS Scotland (Table 1)
Table 1: The three Quality Ambitions for NHS Scotland (May 2010)

Drivers	Quality Ambitions	Benefits of ACP
Person-centred	Mutually beneficial partnerships between patients, their families and those delivering health care services, which respect individual needs and values and which demonstrate compassion, continuity and clear communication and shared decision-making	❖ Improves people's choice, dignity and control by engaging and informing staff, professions and wider public ❖ Working with individuals and carers to identify their own health/social care needs ❖ Improving communication and provision of relevant information to enable shared decision making/informed choice and participation in individual care needs ❖ Enables people to be cared for and die in the place of their choice ❖ Patient's concerns identified at the earliest stage possible to improve patient care pathway (not just last few weeks or days of life) ❖ Improves satisfaction of patient/carer experiences with services, avoiding dissatisfaction and / or complaints by providing high quality end of life care involving the family
Safe	There will be no avoidable injury or harm to people from health care they receive, and an appropriate, clean and safe environment will be provided for the delivery of health care services at all times	❖ Contributes to the avoidance of unnecessary hospital admissions ❖ Prevents where possible, crisis situations ❖ Care that is evidence based with regard to treatment/decisions made with regards to health care needs
Effective	The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated	❖ Contributes to the avoidance of unwanted treatments during end of life ❖ Provides better continuity and coordination of care ❖ Promotes health & social care integration and communication ❖ Facilitates cultural and behavioural change ❖ Enables safe, effective and person-centred care to be sustained through phases of health care changes

Project Activity

Key steps that were undertaken through focused project activity, and which demonstrate Phase 2 KPIs[8] include:

ACP training in Lanarkshire Care Homes: ACP training with Lanarkshire Care Home staff continued throughout Phase 2. A focused approach was used to address the following challenges and learning needs to establish, embed and sustain high-quality ACP records and relevant communication channels within the identified Care Homes.

Staff support / ACP continuity: There was a focus on the identification of a link Care Home ACP Champion(s), manager or named contact for training or support requirements. The role also included feedback to the project manager with regard to monthly progress updates or relevant ACP issues in the home. The high turnover of staff resource in many Care Homes caused a challenge in continuity of ACP processes within some homes, especially when there was a change in manager or Stakeholder Company. During transitions ACP was not necessarily a priority within their care setting.

This was addressed by:

- Informal discussions with company representatives to highlight benefits of the ACP process for residents, carers and staff;
- ACP support and training for relevant unit managers and staff (Registered Nurses and non-Registered Nurses);
- Attendance at and ACP awareness sessions at Residents' family meetings.

Actions delivered to embed red flag criteria/self-management process: A key area of concern was a lack of clear understanding of the self-management steps and actions required by staff to deliver a safe and effective approach to meeting person-centred care needs, encompassing steps to de-escalate crises. This was highlighted by verbal feedback during home visits and at training sessions. Ambiguity about the red flag /self-management pages of the ACP document was an issue.

Key steps taken to address these issues were:

- Education to ensure all staff knew the importance of the red flag pages/self-management steps to effectively manage early indications of health change;
- Providing staff with relevant information to help them understand health conditions and changes over time;
- Care home staff engaging with ACP in a care setting were offered further training, regular updates and support visits as required throughout the project
    - This included a content check of existing ACPs in the home, identification of key areas of need (where there remained an issue with the care plan and content);
- Guidance to further help and support staff was offered in the form of example templates, guidance notes and analysis of unscheduled hospital admissions which may have been avoided. The outcomes of the key priority interventions are demonstrated in figure 2.

8 KPI's, Key Performance Indicators

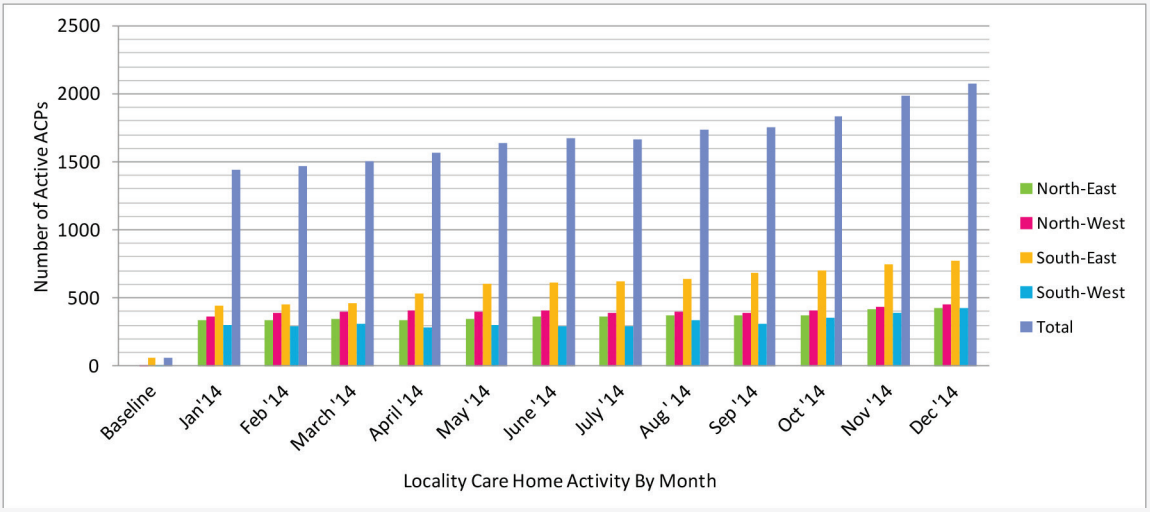


Figure 2: ACP Progress in Lanarkshire Care Homes from Baseline to December 2014

A collaborative approach to person-centred care was reinforced during all visits and email correspondence to Care Homes. All staff were encouraged to communicate and share completed or developing ACPs with the relevant health care professionals and GPs. This ensured that the appropriate health information was updated and documented within the ACP. The process helped to strengthen communication channels between individuals and care providers, while supporting future decisions with regard to personal care. This is illustrated in figure 3:

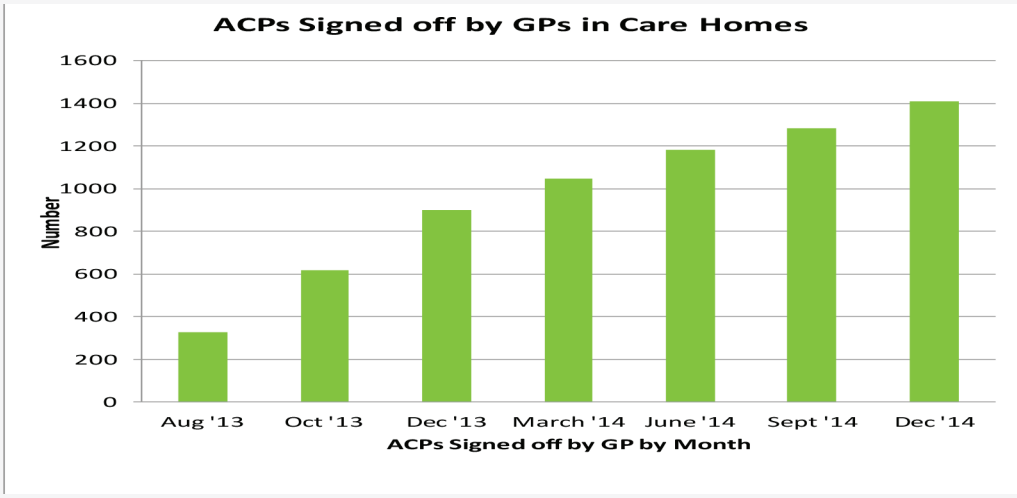


Figure 3: ACPs signed and reviewed by GPs in Lanarkshire Care Homes August 2013 – December 2014:

To ensure continuity and ownership of the ACP process within different care settings, all staff were supported to become proactive with their approach to the ACP process. Examples of this included initiating the conversation about ACP at residents' meetings or encouraging the process at an opportunistic time.

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

Feedback from an ACP Questionnaire, North Lanarkshire Care Home

ACP awareness training and support to Primary Care Staff

Support and guidance processes remained ongoing to Community District Nursing teams. This included relevant guidance to facilitate staff to have the confidence and skill when initiating ACP discussions with patients and families at the right time. This included ACP awareness sessions with locality teams, to embed the approach in practice while continuing to reinforce ACP awareness at various locality events.

The main aims of this were to facilitate a person-centred approach to care planning, where people were supported to make informed decisions about managing their own health and wellbeing. Anecdotal evidence suggests that the ACP process can enable positive experiences of health-care interactions and facilitate personal outcomes for patients and carers.

ACP awareness and support to GPs and practice staff

ACP was included within the GP QoF from April 2013. The aims and objectives were to embed the process within discussions at a practice level, along with polypharmacy reviews and improve care quality such as:

- Enhancing person centred care, dignity choice and control;
- Enhanced and effective communication between patient, carer and health or social care professional who may be involved in care management;
- Care within preferred place, and choice where appropriate;
- Safer use of medicines and reduced harm from inappropriate interventions.

(BMA Scottish Quality and Outcomes Framework guidance for GMS contract 2014/15)[9]

The project team worked with GPs and practice staff to support the ACP process with relevant patients, to ensure sharing of key information through the designated electronic processes e.g. eKIS.

9 bma.org.uk/-/.../qof%20guidance/gpqofscotland_guidance2014-15.pdf

The NHSL eKIS is an extension to ECS[10] which is available to A&E Departments, Out of Hours Services, NHS24, Scottish Ambulance Service and relevant areas of the acute division. The process is designed to be used for patients' with:

- Long term conditions;
- Mental health issues;
- Unusual conditions. For patients who may have difficulty in remembering crucial details if they become ill. www.nisg.scot.nhs.uk/keyinformationsummary

The increased ACP/eKIS activity between the GP practices in Lanarkshire is demonstrated in figure 4.

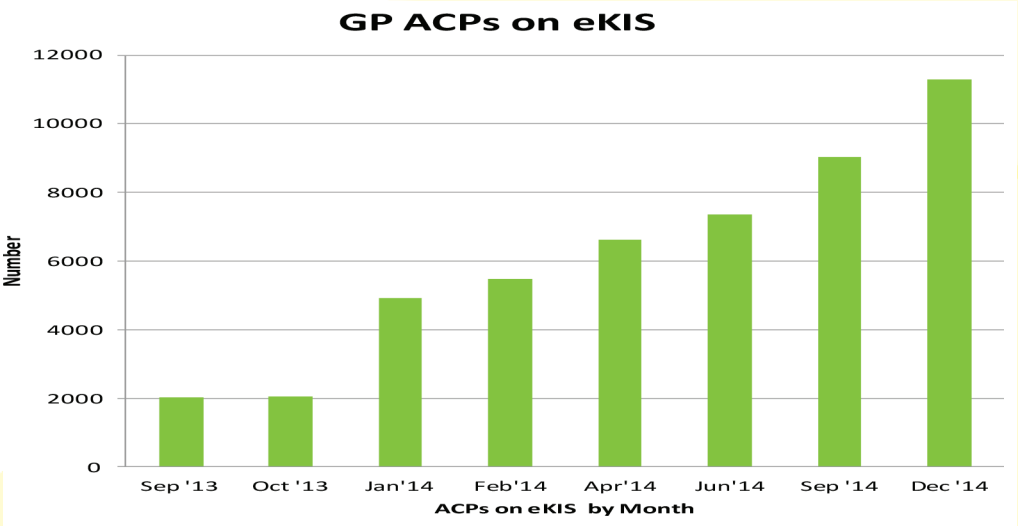
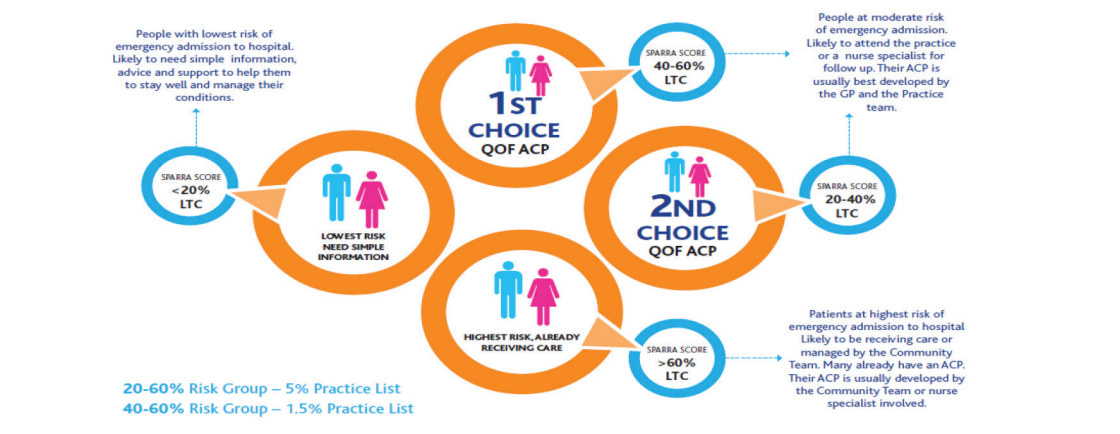


Figure 4: eKIS progress, September 13 – December 2014

Locality ACP awareness sessions were provided for GPs and practice staff to inform and share good practice. This also included specific facilitation from NHSL e-health department to support electronic sharing of information, including step-by-step guidelines. A WebEx presentation with **JIT**[11] Scotland was made to support practice staff **(Figure 5)**. An ACP awareness session was also delivered to practice nurses through a NHS Education for Scotland **(NES**[12]**)** event for professional development. Ongoing activity continued throughout the project to fully embed the knowledge skills and processes involved with ACP and person-centred care.

10 ECS, Emergency Care Summary
11 JIT, Joint Improvement Team
12 NES, NHS Education for Scotland

Figure 5: Walking Through Anticipatory Care Planning, Nhs Scotland. Jit Webex Presentation 2013



ACP awareness and support to staff in acute hospital settings

Following guidance from the HSMR Inspection review (2013), the project team was asked to facilitate ACP awareness sessions within acute hospital settings in Lanarkshire. This included an initial analysis of staff learning needs. The findings from this analysis informed the team on the level of ACP training and educational support required within the acute sector. The focused activities were based on the learning needs identified below (figure 6).

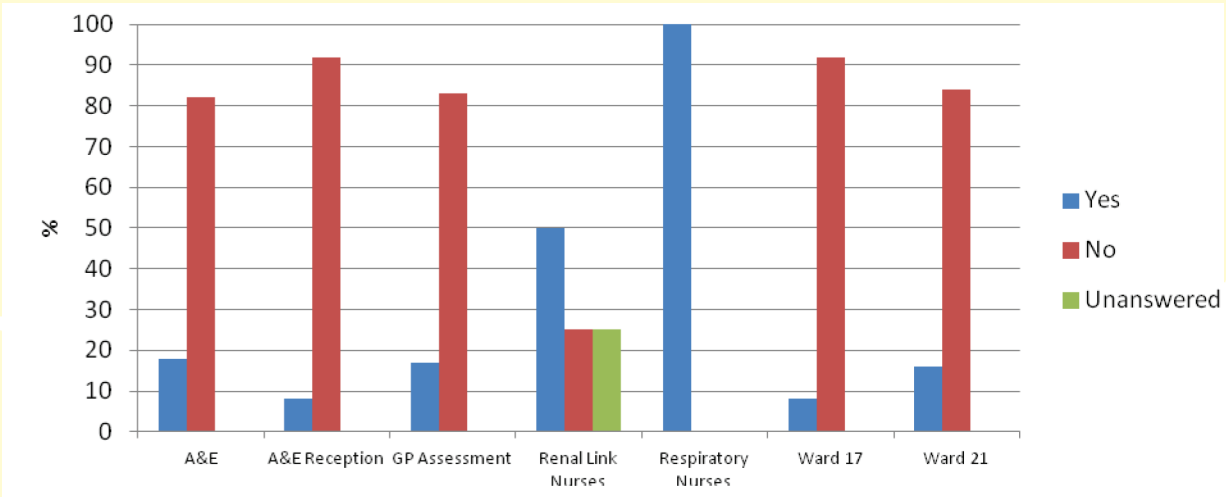


Figure 6: Question administered to acute sector staff: Have you ever initiated an anticipatory planning conversation? Results presented by specialist area

The initial training for acute sector colleagues was tested at Monklands District General Hospital. There was support from the senior management team to facilitate ACP awareness sessions in identified departments. The ACP project team was identified within the site and included a site lead and **SCN**[13]. Departments supported were: **ERC**[14] advisors; A&E reception staff; GP assessment bay; A&E department; Emergency Receiving Unit.

A training schedule was agreed by the SCN[13] in the above departments. ACP[14] Champions/ link nurses were identified within all test departments. An ACP resource pack was developed for (and used in) training sessions for educational purposes and further guidance. Relevant dates for awareness training sessions were advertised on weekly staff briefings to all areas. Opportunistic training visits to the departments also helped to maximise staff attendance.

This was replicated in other acute and community hospitals to facilitate collaborative learning and engagement with the process. The main aims were to embed ACP knowledge and awareness, and ensure all relevant ACP information was recorded and communicated to staff on admission or clerk-in process. This included a printed copy of eKIS information being available for the admitting physician.

All discharge information (change in medication, treatment, outpatient appointments) was communicated to the GP or Community Nurse in the discharge summary. Following discharge, this enabled the GP to update information held on the patient's master eKIS template. Staff were encouraged to record changes as appropriate in the "hospital admissions" pages of the document. This process was used to update and inform carers or staff (e.g. in care homes) who did not always receive a direct discharge summary.

To identify if a patient had an ACP in place, the ERC hub advisors asked a further two questions when GPs contacted the Hub - **"Does the patient have an ACP?"** and **"Does the patient have an ACP on eKIS?"** This information was recorded for all relevant admissions to the three acute sites and communicated to the corresponding receiving unit or A&E reception areas **(Figure 7)**.

A weekly ERC hub referral audit was undertaken and updated. This unique process enabled follow up of relevant Care Home admissions, and facilitated the required support to staff to initiate ACP discussions with residents and carers, where ACP may have benefitted the individual. Similarly, relevant patients were signposted to specialist nurses for condition specific admissions e.g. respiratory and heart failure admissions.

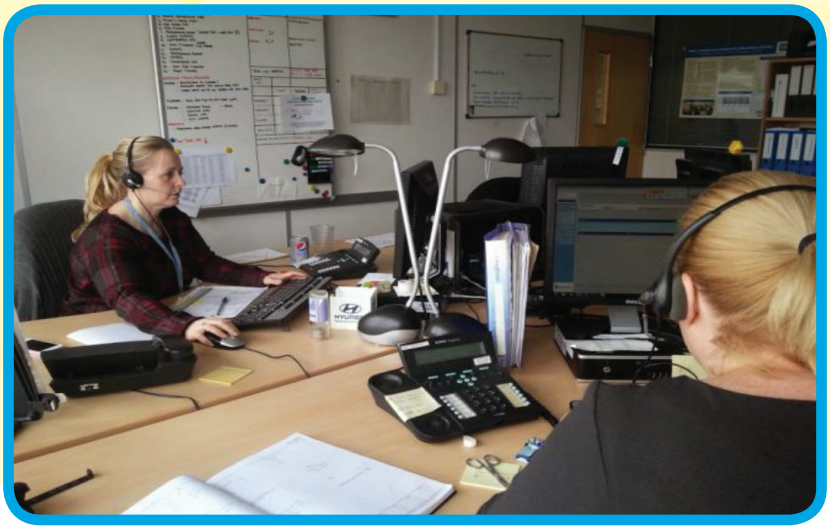


Figure 7: ERC Hub Advisors, Hairmyres Hospital

13 SCN, Senior Charge Nurse

14 ERC, Emergency Receiving Centre

Sharing ACP Knowledge And Learning: 2nd Commonwealth Nurses Federation ; Nhs Scotland Event

ACP has been promoted at a variety of stakeholder, multiagency learning and sharing events. Furthermore, the ACP process has been included within a number of postgraduate educational programmes. It was also presented at the 2nd Commonwealth Nurses Federation (CNF) in London **(figure 8),** which was attended by health practitioners from over 26 countries alongside CNF board members. The CNF was hosted on the eve of Commonwealth week, celebrating and showcasing international excellence in health practice and commitment to change. The focus was on how agents of change in various health settings can incorporate innovative practice, to deliver effective measures to enhance and improve healthcare.

Figure 8: the 2nd CNF Conference in 2014

The ACP team were invited to present a poster at the NHS Scotland Event 2014 **"Spreading and Sustaining Quality"** in care. The work was recognised and awarded the highly commended rosette.

National Power Of Attorney Awareness Campaign

Wider Phase 2 activities included joint working with other NHS Scotland health boards, to promote and raise public awareness through a national campaign with Power of Attorney (PoA). Within Lanarkshire, this campaign included local ACP and PoA activities **(Figure 9)**. Campaign activity is ongoing and delivered through various media channels including TV advertising, radio advertising, website information on **www.Mypowerofattorney.org.uk**, social media updates via twitter, facebook, NHS Lanarkshire Patient Opinion, public poster displays throughout Lanarkshire and advertising in leisure centres.

Figure 9: Example from the ACP/PoA campaign in Lanarkshire

Project Benefits/Impact

The ACP project has made substantial progress with identified deliverables set out in the aims and objectives outlined in the project plan.

Key benefits include:

- Aim: within the original PID the target was set as 50% of Care Home residents offered an NHS Lanarkshire ACP to have one in place by April 2014;
- Metric achieved: 56% of Lanarkshire Care Home residents had an active ACP in place by March 2015 **(Figure 10)**

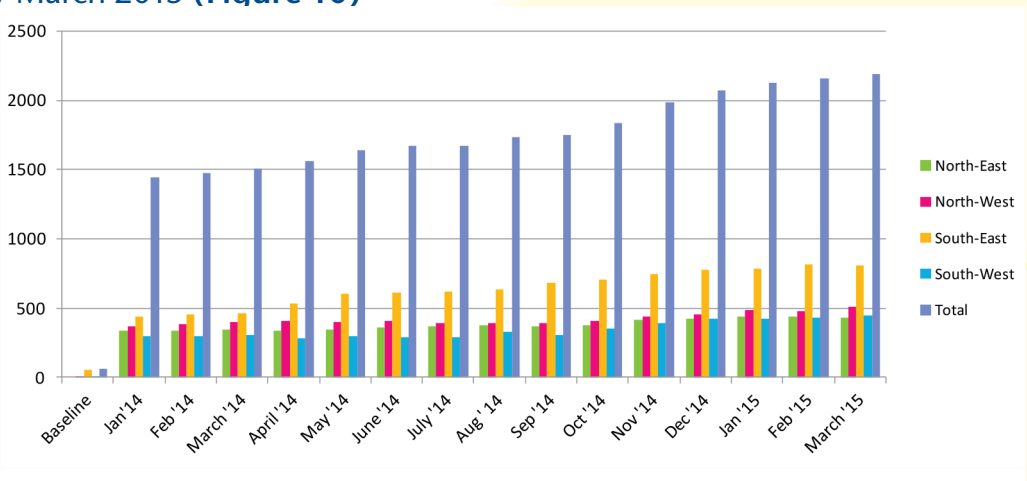


Figure 10: Care home ACP progress, Baseline to March 2015

"ACP information leaflets are now included in our Care Home information for new residents and carers. It's a gentle way to encourage early thinking and prompt family discussions"

Comment from Care Home ACP link nurse

- **Aim:** Key ACP information is available to identified and relevant care providers electronically as it comes on the system via eKIS;
- **Metric achieved:** 15,383 ACP/eKIS Key information available to share by March 2015 **(figure 11)**

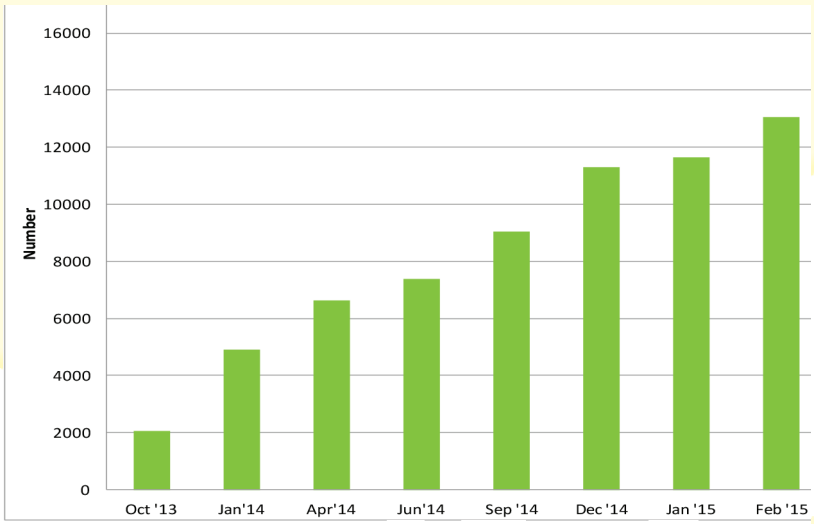


Figure 11: GP/ACP eKIS progress, Oct 2013 – Feb 2015

- **Aim:** ACP to be undertaken with relevant individuals/carers and when required and used to inform place of care as per individuals preference, avoiding unnecessary acute hospital admissions where possible.
- **Metric achieved:**

85 of the 87 care homes in Lanarkshire are implementing and embedding ACP within their work setting

264 Care home staff received ACP training (North Lanarkshire) 484 Care home staff received ACP training (South Lanarkshire)

All Care Home staff received regular follow-up visits and support, post-training, to embed knowledge, understanding and skills in practice. Wider ACP promotion was also provided at **"carer update"** meetings, to inform and advise carers about the process and benefits of ACP and dispel uncertainty.

ACP awareness has improved among staff in Lanarkshire care homes, primary and secondary care settings, and among the various carer groups in Lanarkshire. There has been a steady increase in interest, ACP activity and engagement from relevant individuals and carers with regard to the process. This included ACP representation and presentation at stakeholder events, with further dates planned for 2015. Monthly care home questionnaire returns have progressively shown improved reporting and positive outcome feedback from care home staff and managers.

"The ACP was a huge benefit to our resident at a time when he was unable to express his wishes. This has left a positive and lasting experience for the whole family"

Comment from ACP Care Home Champion. South Lanarkshire

431 Care Home residents with an ACP remained in their preferred place of care following a change in health (January 2014 – March 2015).

This was reported by staff as being beneficial for individuals and carers, with many examples of positive outcomes as a result of planning ahead and communicating their wishes through their ACP.

Estimated efficiency savings and productive gains based on 431 Care Home residents with an ACP who remained in their preferred place of care:

- Average length of stay – 5 days at £350 per day (http://www.isdscotland.org/Health-Topics/Finance/Costs;
- Average cost per patient for an average 5 day stay = £1,750;
- **431 patients = £754,250 estimated costs savings over the time period.**

Aim: Relevant acute sector staff trained and supported on ACP processes. ACPs to be identified and enacted at place of residence and/or in an acute setting.

Metric achieved: From May 2013 to March 2015, **970** NHS staff attended available ACP awareness sessions within NHS Lanarkshire. This included staff from Community DN teams, acute sector sites, Community Hospitals, Allied Health professionals, staff from learning disability teams, and 35 staff from integrated care units.

In addition to the sessions there were various ACP promotion and workshop sessions at locality events, with positive feedback from attendees (figure 12).

Focused ACP awareness sessions and workshops at events were facilitated in primary and secondary care. These included collaborative learning sessions with locality Carer Network groups in Lanarkshire. There was a positive response from patients, service users, carers and staff groups to the information provided and learning outcome achieved. Wider interest to the process, and requests for continuation of awareness sessions for future training and relevant updates, were highlighted at all sessions.

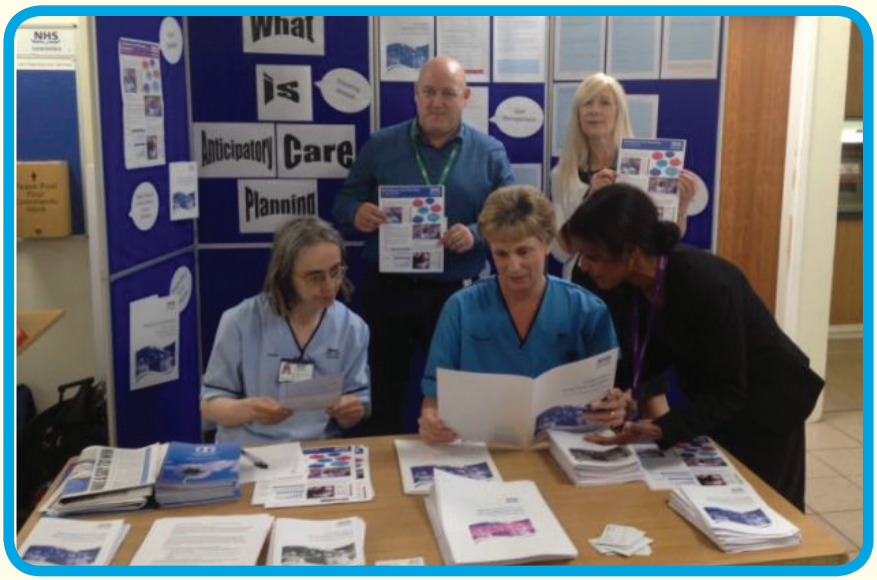


Figure 12: ACP promotion, Wishaw Hospital

"My GP mentioned this to me at my last appointment, but I was not sure about ACP at that time. After the event today and all the information I have been given, I will definitely talk to my family and complete it. I want to make sure everyone knows what I want and what I don't want whilst I still can"

Comment from a visitor at ACP awareness event 2014

"Anticipatory Care Planning made me think about my own health and writing down my preferences and wishes gave me a feeling of control. This enabled discussions with my partner with regards to my health needs and identify the signs and symptoms to look out for which may indicate a change in my condition"

Comment from a Patient following ACP promotion at a stakeholder event 2014

- Aim: Progress data that monitors performance against stated deliverables;
- Metric achieved: 80% increase in GP/ACP sign-off and review in Care Homes from August 2013. There was a substantial increase in ACP activity and sharing of relevant information to GP's in Care Homes **(figure 13).**

ACPs Signed off by GPs in Care Homes

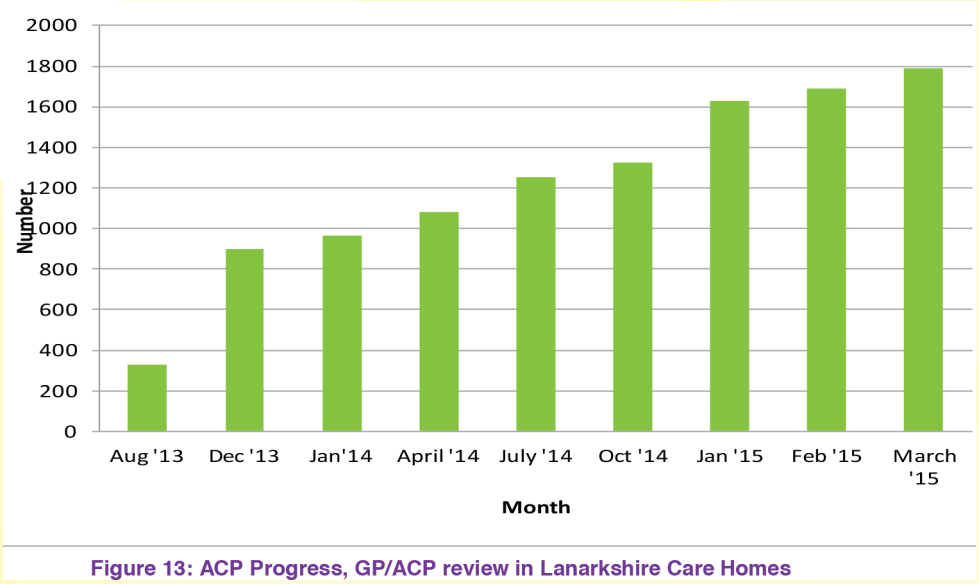


Figure 13: ACP Progress, GP/ACP review in Lanarkshire Care Homes

- Aim: Raise wider public ACP and PoA awareness in Lanarkshire through the national campaign activity;
- Metric achieved: A substantial 34% increase in PoA registrations in the first quarter of the campaign from Lanarkshire and Glasgow City areas, compared with the previous year. Due to continued interest and demand, further steps to continue the campaign over 2015 are planned.

Conclusions

The Phase 2 ACP project has made substantial progress in delivering against the aims and objectives as outlined in the Project Initiation Document, and as directed by the project sponsors and project lead.

The project has faced some challenges with its implementation due to delays in appointing staff resource to the project team. Nevertheless, once the team was established, the desired progress was made with rolling out and implementing ACP within the defined areas whilst continuing the focus and support of ACP within Lanarkshire Care Homes.

Feedback has been very positive from all staff involved and from patients and carers at locality events, especially on the beneficial impact that ACP can (or, when in place, has) made to their care. The approach and processes involved with ACP should always be person centred and demonstrate personal choice and preference.

The ACP approach also encourages individuals and carers to plan ahead with regard to potential changes in health and well being. This includes early identification of health deterioration or need with a clear management plan to de-escalate potential health crises and undue anxiety.

Phase 2 of the project demonstrates that ACP can be beneficial to individuals/carers with long term-health conditions and for service delivery. Further work is required to embed ACP within NHS Lanarkshire's Health and Social Care Partnerships to ensure best practice becomes common practice.

We acknowledge the concept of ACP will continually evolve over time, responding and adapting to the needs of people. Agencies and organisations need to work together to embrace and support ACP to:

- Embed ACP methodology and practice across health and social care in Lanarkshire;
- Ensure effective communication and information sharing to make sure expressed patient and carer needs and wishes are central to decision-making processes;
- Respect the experience and knowledge of individuals and carers about their condition, circumstances and preferences for care.

Good partnerships between individuals, and health and social care providers can encourage better communication of patients' wishes with regard to their care and treatment, and ultimately enhance person-centred care.

2015 Project Closure Recommendations

Reflecting upon progress made during phase 2 of the ACP project, the project team recommends that North and South Lanarkshire Health and Social Care Partnerships:

- Continue supporting health and social care staff to firmly embed ACP into the culture of health and social care delivery, keeping the person central to all elements of care:
- Incorporate and connect with other work streams which synergise and support ACP;
- Provide the necessary documentation to agencies to support the ACP processes:
- Explore electronic solutions to facilitate the communication of relevant ACP information to those who need to know;
- Take every opportunity to include ACP in undergraduate and post-graduate education;
- Continue to raise awareness of ACP within the general public.

Note of Acknowledgement

The ACP project manager would like to thank all identified stakeholders, (community and acute) staff who have positively engaged with the process throughout Phase 2. Thank you also to all Care Home Managers and ACP Champions who have demonstrated their hard work and commitment to the project, which has been evidenced by the substantial progress of ACP within Care Homes in Lanarkshire.

A special thanks to our public partners, carer organisations and voluntary groups for their continued commitment to ACP.

Thank you to the project team, Margaret Yates, Anthony Brady, Claire Arnott and Amy Craggs for your hard work and determination with Phase 2 aims and objectives.

Finally, to Janette Barrie and Colin Blair, thank you for your continued support, project guidance and mentorship throughout Phase 2.

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