

Anticipatory Care Planning

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What would
be important
to you?

Maintaining Dignity



Avoiding pain and suffering



Living as long as possible



Remaining independent



What is Anticipatory Care Planning?



An opportunity to think about what is important.



A guide to help people understand who you are and what matters to you.



A tool to help you feel in control about the decisions that affect you.



A safety net, in case you are not able to communicate your wishes later on.

What Anticipatory Care Planning is **NOT!**



A Legal Document
– it is a guide to wishes and preference, not legal instruction



Set in Stone
– it can be changed and updated easily, and as often as needed



A “Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)” Form
– this is a separate document (and conversation).



Mandatory
– it is completely voluntary, however we think it is a great idea!

Why is it important?

Person Centred Care

Better Support

Promotes Conversation

Future Planning

Shared Information

Better Histories

Successful Discharge

If we think about the people you support...

Who or what situation would trigger these conversation?

People

Condition

Setting

Person
Carer/POA
Health &
Social Care
Community
Services

New
Diagnosis
Change to
condition
Additional
Health
Conditions

Hospital
admission
/discharge
New Living
Arrangement
End of Life
Care

We use the word "**DISCUSS**" to help everyone remember the different topics that are part of **Anticipatory Care Planning**.

D	Decisions	How can we help you make informed decisions?
I	Interventions	What you would like to happen and what you would not?
S	Social Relationships	Who is important to you and who can give you support?
C	CPR	What do we mean by CPR? Is this appropriate for you?
U	Understanding You	What matters to you?
S	Surroundings	Where is the most appropriate place for treatment?
S	Services	What support and services help you?

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 (<i>health problem</i>) 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.

Barriers & Challenges



Communication

Check with the person
Establish best method
Who else can support

Resistance

Plan for small changes
Parallel Planning
The right time

Family Dynamics

Ensure key people aware
Discuss fears & concerns
Common ground

Capacity

Value what is important
POA / carers
Previous Notes / Best Interests

Difficult Topics

Condition / Experience
What you know / comfort level
Re-assurance / Support

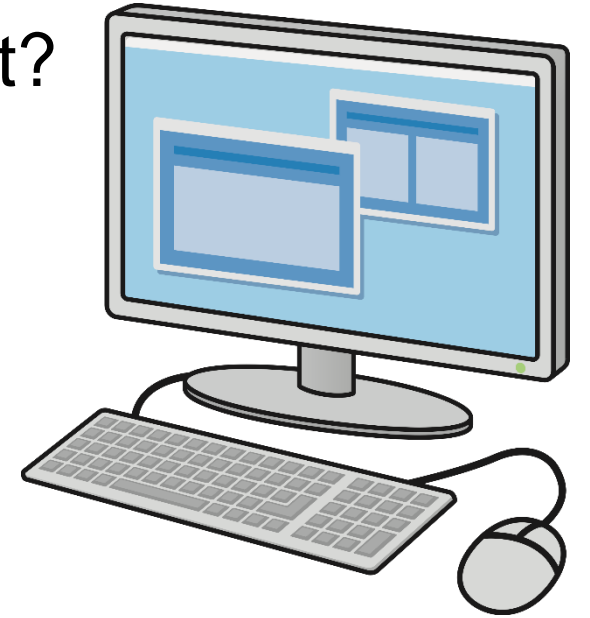
Managing Expectation

Realistic Conversation
What's appropriate / feasible
Be honest

Time & Paperwork

Information available
Use resources on hand
Key information

- What sources of information do you currently look at?
- Where do you record the information you gather?



- Do you have information that might be useful for other services?

- Can you plant a seed?



Can someone who lacks capacity have an ACP?

YES!

Should someone who lacks capacity be involved in these discussions?

YES!

Who else should be involved?

Family

POA

Guardian

GP

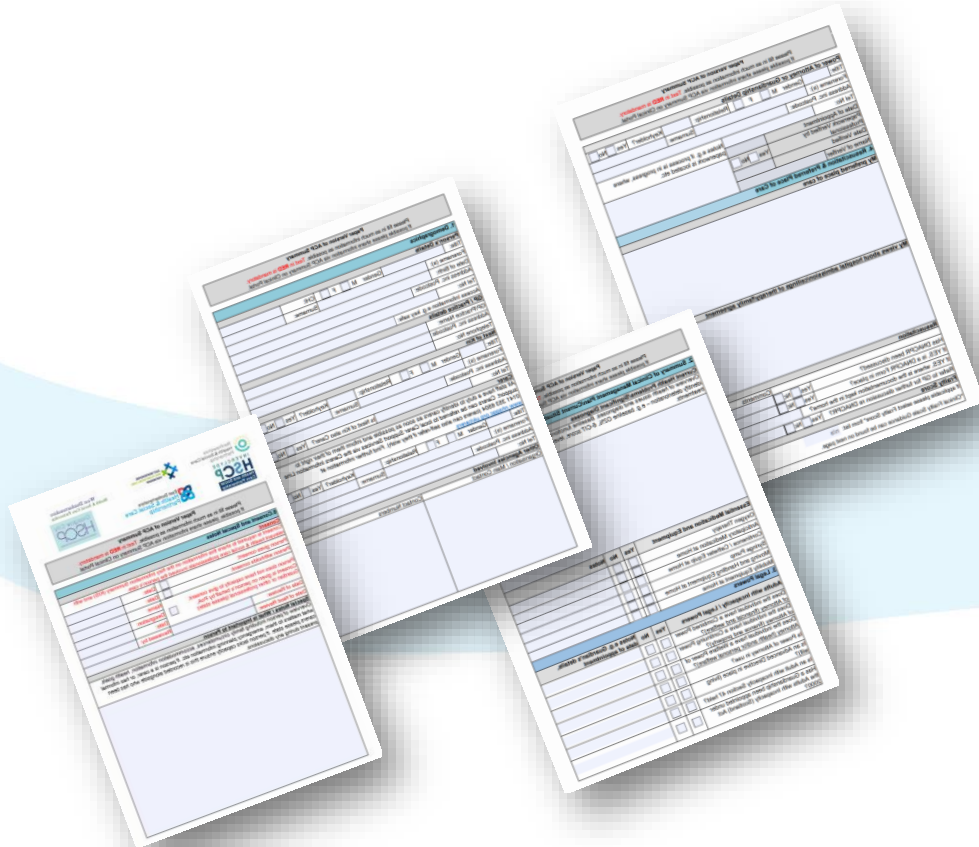
Is consent required to share this information?

Not necessarily...

What does a plan look like?

Focus less on what it looks like...

...and more on what it tells you!



- **What** is important? (wishes, preferences, not just about treatment)
- **Why** is this important? (motivations, goals, putting the person and their decisions in context)
- **Who** is important? (NOK, Legal Guardians, key staff)
- **Where** they wish to be treated? (Hospital? Care Home? Both?)
- **How** are they at the moment? (current medical issues, treatments, prognosis etc.)

Think.



Talk.



Plan.



Helping you plan for the future.

www.nhsggc.scot/planningcare | [@NHSGGC_ACP](https://twitter.com/NHSGGC_ACP)

ACP
Pathway
Training



 **NHS**
Greater Glasgow
and Clyde

Keep up to date with all the latest developments from the Anticipatory Care Programme.

Click here to sign up to our mailing list.

You can unsubscribe at any time by emailing ACPSupport@ggc.scot.nhs.uk

 **NHS**
Greater Glasgow
and Clyde

Click here for more information

Could you be an ACP Champion?

 **DISCUSS**
Guides

 **NHS**
Greater Glasgow
and Clyde

FOLLOW
US ON TWITTER
[@NHSGGC_ACP](https://twitter.com/NHSGGC_ACP)

HELPING YOU PLAN FOR THE FUTURE.
WWW.NHSGGC.ORG.UK/PLANNINGCARE

Important Links

Website: www.nhsggc.scot/planningcare

Twitter: [@NHSGGC_ACP](https://twitter.com/NHSGGC_ACP)

Email: ACPSupport@ggc.scot.nhs.uk

Training Hub: <https://www.nhsggc.scot/your-health/planning-for-care/information-for-staff/anticipatory-care-plan-training-hub/>

Quicklinks
(Resources): <https://www.nhsggc.scot/your-health/planning-for-care/useful-documents-and-resources/>

Useful Resources

All these resources can be found on our website but you can also use the hyperlinks embedded.

Anticipatory Care Planning Module



Intro What? Who? Why? When? How? Where? Progress

Think. Talk. Plan.



Helping you plan for the future.

Anticipatory Care Planning:
What you need to know

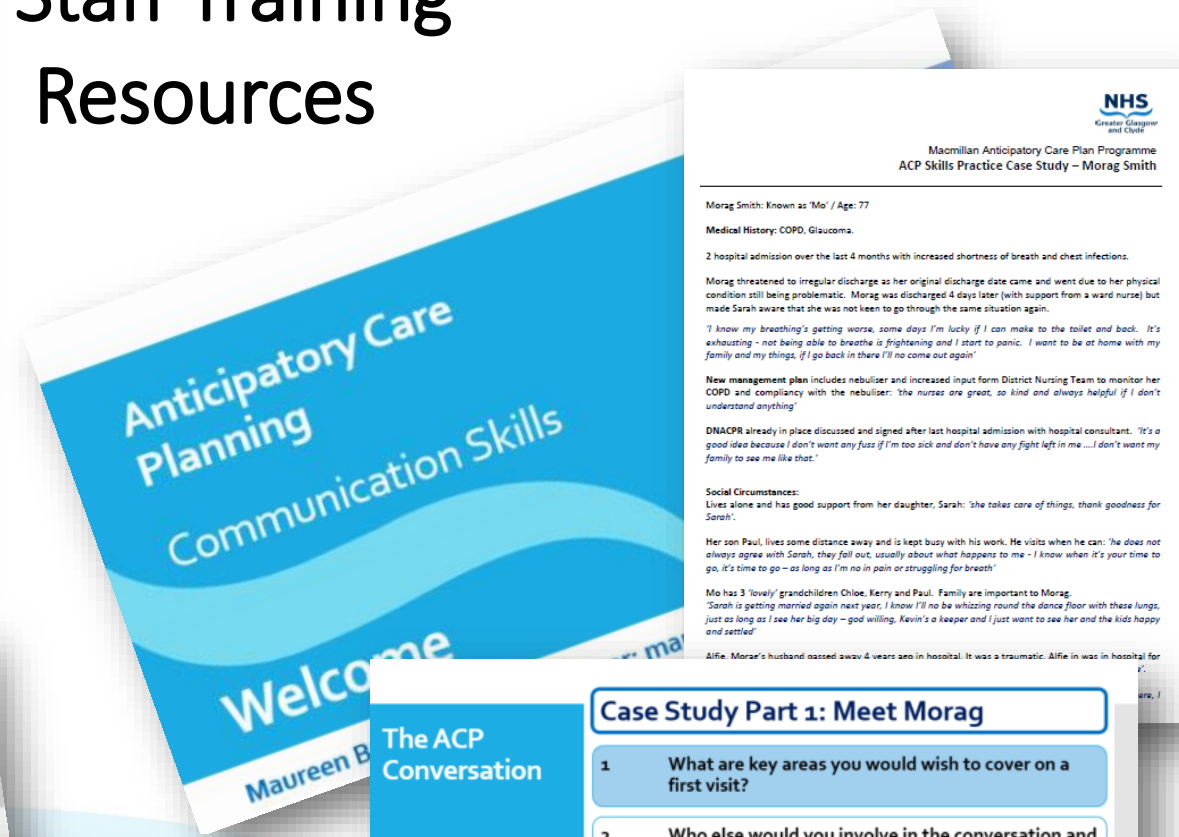
Next

Click the 'Next' button to continue →

There are links to other websites embedded in this module. They will be in a different colour and underlined. If you are viewing this on a web browser, please **right click** on these links and select "open in a new tab".

Staff Training Resources

[ACP Emodule \(available to all\)](#)



Macmillan Anticipatory Care Plan Programme
ACP Skills Practice Case Study – Morag Smith

Morag Smith: Known as 'Ma' / Age: 77

Medical History: COPD, Glaucoma.

2 hospital admission over the last 4 months with increased shortness of breath and chest infections.

Morag threatened irregular discharge as her original discharge date came and went due to her physical condition still being problematic. Morag was discharged 4 days later (with support from a ward nurse) but made Sarah aware that she was not keen to go through the same situation again.

'I know my breathing's getting worse, some days I'm lucky if I can make to the toilet and back. It's exhausting - not being able to breathe is frightening and I start to panic. I want to be at home with my family and my things. If I go back in there I'll no come out again'

New management plan includes nebuliser and increased input from District Nursing Team to monitor her COPD and compliance with the nebuliser: 'the nurses are great, so kind and always helpful if I don't understand anything'

DNACPR already in place discussed and signed after last hospital admission with hospital consultant. 'It's a good idea because I don't want any fuss if I'm too sick and don't have any fight left in me...I don't want my family to see me like that.'

Social Circumstances:
Lives alone and has good support from her daughter, Sarah: 'she takes care of things, thank goodness for Sarah'.

Her son Paul, lives some distance away and is kept busy with his work. He visits when he can: 'he does not always agree with Sarah, they fall out, usually about what happens to me - I know when it's your time to go, it's time to go - as long as I'm no in pain or struggling for breath'

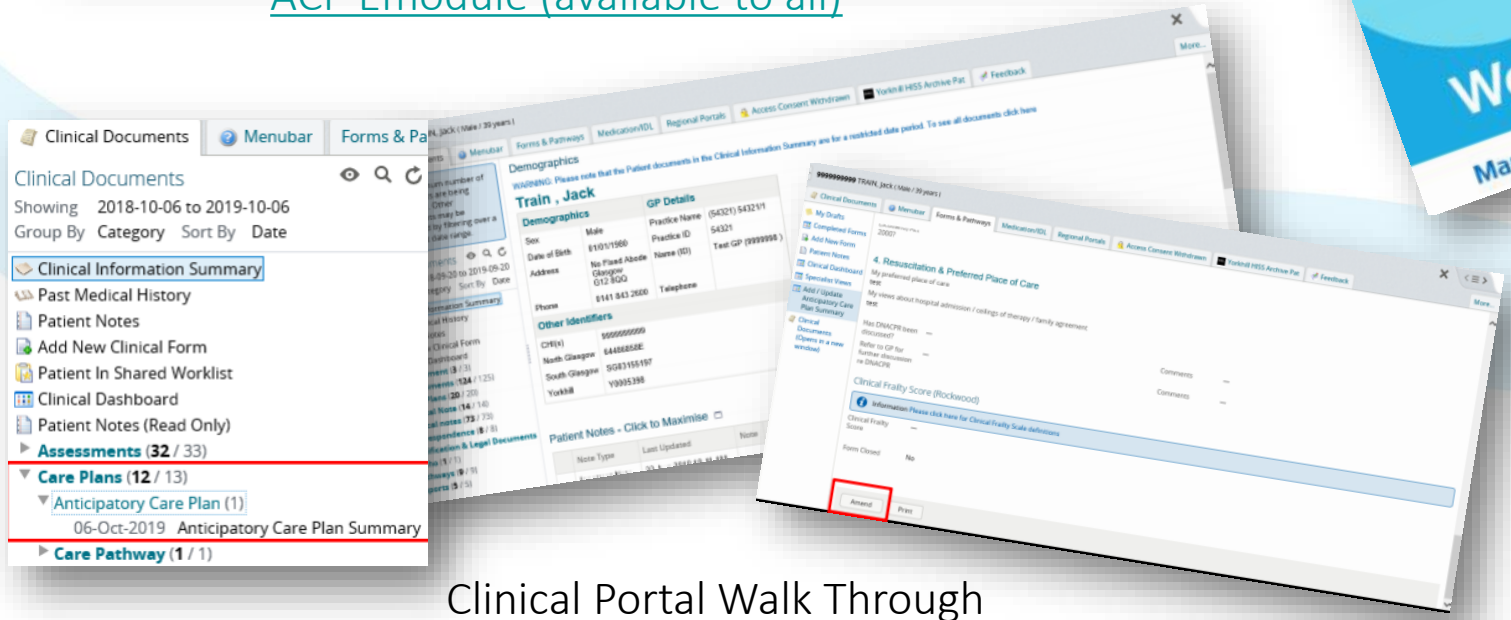
Ma has 3 'lovely' grandchildren Chloe, Kerry and Paul. Family are important to Morag. 'Sarah is getting married again next year, I know I'll no be whizzing round the dance floor with these lungs, just as long as I see her big day - god willing, Kevin's a keeper and I just want to see her and the kids happy and settled'

Alfie, Morag's husband passed away 4 years ago in hospital. It was a traumatic. Alfie was in hospital for

Case Study Part 1: Meet Morag



1. What are key areas you would wish to cover on a first visit?
2. Who else would you involve in the conversation and at what stage?
3. Suggest questions you could ask or statements from Morag to explore more which would open up or keep the conversation going?
4. How would you evidence that a good conversation has taken place.
5. Are there any barriers or challenges in supporting Morag with ACP?



Clinical Portal Walk Through

[ACP Communication Skills Staff Training](#)

ACP Summary Example Library

- [Alan Fulton](#) - An older man who cares for his wife.
- [Monica Hill](#) - A lady with breast cancer receiving support from a local hospice.
- [Elizabeth MacDonald](#) - An older lady with COPD.
- [Ali Malik](#) - A young adult transitioning between child and adult palliative care services. You can also view an example of a [Child and Young People Acute Deterioration Management \(CYPADM\) form](#).
- [Jacqueline Morrow](#) - A parent carer with a daughter on the autistic spectrum.
- [Sophie Morrow](#) - A young woman with autism.
- [Margaret Quinn](#) - An older lady living with dementia.
- [Paul West](#) - A middle-aged man recovering from cancer.
- [Tom Williams](#) - A Care Home Resident.

Website Resources

Anticipatory Care Planning and Winter Planning - Information for Services
What is Anticipatory Care Planning?
 Anticipatory Care Planning is a person-centred, proactive approach to help people to plan ahead and to be more in control and able to manage any changes in their health and wellbeing.

What is an Anticipatory Care Plan?
 The decisions made during these conversations are recorded in an Anticipatory Care Plan. The plan should 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 receive treatment elsewhere if possible.
- information on who should be involved in supporting future decisions about treatment and care.

How can ACP help manage winter pressures?
 By ensuring we know what people's wishes and preferences are, we can make the right decisions if emergency situations arise. This includes whether or not they would like to be admitted to hospital or prefer to receive treatment elsewhere if possible.

What are my responsibilities?
Review Case Load: As winter approaches, all services should review their case load to ensure they are accurate and that they are able to manage any changes in their health and wellbeing.

Start the Conversation: It is the responsibility of all staff, in establishing if people already have an Anticipatory Care Plan on Clinical Portal system will automatically inform the GP when it is updated. This may include their opinions on hospital admission or other aspects of future planning such as Power of Attorney.

Record the Information: Information should be recorded in the ACP Summary on Clinical Portal (also available in PDF). By ensuring we know what people's wishes and preferences are, we can make the right decisions if emergency situations arise. This includes whether or not they would like to be admitted to hospital or prefer to receive treatment elsewhere if possible.

Where can I find more information?
 Visit www.nhs.gov.uk/planningcare to find further information about ACPs and Power of Attorney. You can also find training opportunities including an eModule which all staff should complete (also available on Learnpro GGC028: Anticipatory Care Planning).

Anticipatory Care Planning – Having ACP Telephone Conversations
What is Anticipatory Care Planning?
 Anticipatory Care Planning is a person-centred, proactive approach to help people to plan ahead and to be more in control and able to manage any changes in their health and wellbeing.

At the heart of this 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.

What is an Anticipatory Care Plan?
 The decisions made during these conversations are recorded in an Anticipatory Care Plan.

The plan should 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
- information on who should be involved in supporting future decisions about treatment and care.

Why am I being asked to phone people?
 We know that many staff have been identified as a close contact by the Test and Protect process and as a result are now required to isolate. Whilst this means many services are under extreme pressure to continue to provide face to face support, there is now extra capacity in the system for staff to carry out tasks which can be completed remotely e.g. beginning to engage with people and their families about future planning.

What are my responsibilities?
Review Case Load: All services should continually review their case load to establish if people have an Anticipatory Care Plan on Clinical Portal. If staff are isolating at home they should be instructed by their Line Manager as to which cases should be reviewed.

Start the Conversation: If no ACP has been recorded, staff should contact the person to begin to explore future planning. This may involve asking them to think about specific aspects of their care or reflect on their current experience. It may also be an introductory conversation about the benefits of future planning and signposting people to further information such as Power of Attorney (www.nhs.gov.uk/planningcare). In cases where people indicate that they would like to look over additional information and speak with those that matter to them, staff should ensure this is recorded on case files in order for future isolating staff to follow up with further conversations.

Record the Information: If people give their consent, information should be recorded in the ACP Summary on Clinical Portal. For staff who have no access to Clinical Portal at home, they can use the PDF version and transfer information onto Clinical Portal at the next available opportunity. A guide to using the ACP Summary can be found on the back of this page.

Revisit the Situation: For those who already have an ACP, staff can check with the person to ensure information is correct and up to date.

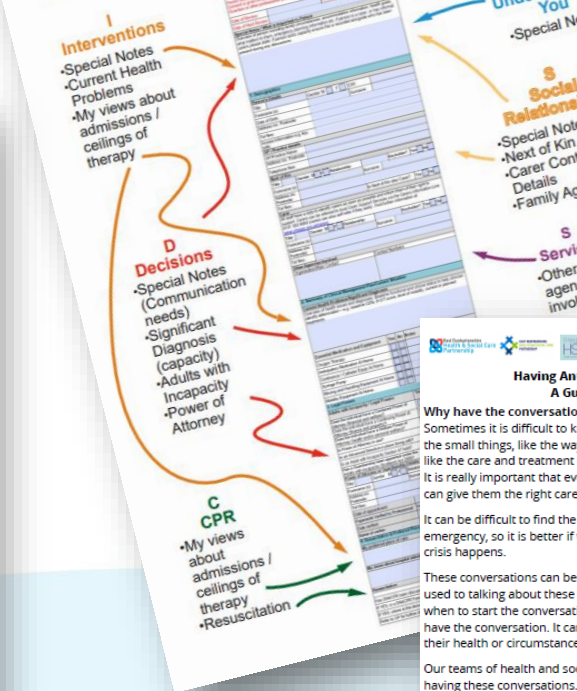
Where can I find more information?
 Visit www.nhs.gov.uk/planningcare to find further information about all aspects of future planning including ACPs and Power of Attorney.

You can also find training opportunities including an eModule which all staff should complete (also available on Learnpro GGC028: Anticipatory Care Planning).

Where to document this discussion?
 You can use the ACP Summary to record any discussions or decisions that are made during an Anticipatory Care Planning conversation. You can access this via Clinical Portal, or complete the Interactive PDF version.

How to use the ACP Summary and DISCUSS topics

This is a copy of the PDF version on the ACP Summary. The sections are identical to those on Clinical Portal.



**Having Anticipatory Care Planning Conversations
 A Guide For Friends, Family and Carers**

Why have the conversation?
 Sometimes it is difficult to know what the person we care for wants. It might be about the small things, like the way they are living day to day. It might be about bigger things, like the care and treatment they would like to receive if they were admitted to hospital. It is really important that everyone has a clear understanding of people's wishes so we can give them the right care and treatment.

It can be difficult to find the right time to have these conversations during an emergency, so it is better if we can talk with our friends and family before any type of crisis happens.

These conversations can be difficult for everyone and easy to put off. If you are not used to talking about these feelings or subjects it can be difficult to know what to say or when to start the conversation. However it can also be really helpful and comforting to have the conversation. It can be a relief to know what someone wants to happen if their health or circumstances change and decisions need to be made.

Our teams of health and social care professionals have had years of experience in having these conversations. We are happy to answer any of your questions and talk about these subjects at a pace that is right for you and the person you support.

How does it work?
 We would like to help you and the person you care for write down their thoughts so we can share it with everyone who needs to know. This is called an 'Anticipatory Care Plan' or ACP and it will help make sure that they receive the right treatment, in the right place, at the right time.

We have suggested some ideas of things we would like to talk about with you and the person you care for. We use the word "DISCUSS" to help everyone remember the different topics that are part of Anticipatory Care Planning.

Have a think about each of them and what you would like us to know. You might not be ready to talk about some of these things right now. Don't worry we can talk about them at another time.

Once you feel ready to have this conversation, let us know so we can arrange a time to talk with you and the person you support.

What could we "DISCUSS"?
 We want to make sure that you understand everything that we are talking about. Please let us know if there is anything that would help you understand things more.

D Decisions
 If you would like other people to be involved in these conversations please let us know. If there are people you would not like involved in these conversations please tell us.
 You might also have someone who is your "Power of Attorney". We would like to speak to them as well. If you would like to know more about Power of Attorney then please visit our website www.nhs.gov.uk/scot/planningcare
 We would like to talk to you about things we could do to help you, as well as things you might not like to happen. We would also like to talk to you about treatments that we don't think would be good for you.

I Interventions
 We would like to talk about what life is like just now for everyone. We would like to talk about any informal care or support that you receive from other people. This might be things like shopping, making meals or providing personal care. It could also include emotional support.
 We would also like to know if you give this type of support to anyone else. If you do then you might be a carer. This will help us all to make sure that plans are in place to support everyone if you become unwell or there is a change in circumstance.

S Social Relationships
 We would like to find out more about help and support available for carers in your local area call the Carers Information Line on 0141 353 6504.
 Cardiopulmonary Resuscitation (CPR) is a process which tries to restart someone's heart. In most cases it will not be successful. We would like to talk to you about whether this might be appropriate for you and how you would like to be cared for.

C CPR
 We would like to talk to you about what makes you happy and brings you joy. This might be things like religion or faith, but could also involve spending your time and the "little things" that bring you joy.
 We would like to talk to you about where you would like to receive care and treatment. This could be short or long term treatment. We might also like to talk to you about where you would like to receive end of life care. This could be at home, hospital, a hospice or a nursing or residential care home.

U Understanding You
 We would like to talk to you about services that may already help you in your life, or other services that could be useful. This might be things like district nurses, or a social care service like Carer Support Services. We would also like to know if you would like support services like Carer Support Services.

Thinking about the Future Ver 5.0 - May2021 Created by Jennifer Watt

Winter Planning Toolkit

**DISCUSS Guides
 for Staff and the
 Public**

Just La

ACP SOP for all staff
across HSCP, Primary
Care, Acute and
independent care sector

[Access here.](#)

