Anticipatory Care Planning and Neurological Conditions Webinar

Question and Answers

During the webinar many of you had a lot of very good questions which we unfortunately did not have time to answer. We have taken all of these questions and summarised them below into themes.

**ACP – Anticipatory Care Plan*
**KIS – Key Information Summary*

Access
Question 1: AHP Access – where would the ACP be stored? (i.e. healthcare systems)
An ACP can be captured in various tools then downloaded and saved or can be written up and stored – the latter being considered best practice. If this is in a care setting, the ACP would ideally be stored in patient notes. The key parts of the ACP should be highlighted in the special notes section of the KIS so that they can be accessed by professionals across different healthcare settings. More information on ACP and all of the national tools available can be found at www.ihub.scot/acp.
Question 2: Social Work Access – where would the ACP be stored? (i.e. healthcare systems)
We cannot confirm if social work has access to ACPs, similarly, they could be stored differently within each NHS Board also. If you are unsure, or unable to access an ACP, it may be advisable to speak to the patient and ask if they have thought about the future or to work with the wider multidisciplinary team for this purpose. More information on ACP and all of the national tools available can be found at https://ihub.scot/acp.
Question 3: Can care homes within NHS Greater Glasgow and Clyde access clinical portal?
Within NHS Greater Glasgow and Clyde, there is a clinical portal that has the capacity to add a patients ACP. However, we cannot be sure if all care homes have access to this portal. It is worth noting however, that you should always check with any liaison nurses or similar professionals working within the care home, as they may have access to clinical portal. For more information please see the NHS Greater Glasgow and Clyde ACP Information for Care Homes webpage, which includes details on how to use the clinical portal, and what to do if you don't have access. More information on ACP and all of the national tools available can be found at https://ihub.scot/acp.
Question 4: Does social work have access to clinical portal?
As outlined above, NHS Greater Glasgow and Clyde have a clinical portal that has the capacity to add a patient's ACP. However, we cannot be sure if social work have access to this portal. For further information on how to update records, please see the ACP Information for Care Homes webpage, and additionally the webpage on Keeping Records up to Date. More information on ACP and all of the national tools available can be found at www.ihub.scot/acp.

Process

Question 5: Should an anticipatory care plan be reviewed regularly?

Yes, an ACP should be reviewed regularly. It should be reviewed in compliance with GDPR and in conjunction with the patient.

The 4 steps to ACP are outlined below:

1. **Preparation and planning**
   This involves identifying who you will be having the ACP conversation with, then preparing yourself and the person for that conversation.

2. **Meaningful conversations**
   Meaningful conversations with an individual, their families and / or legal proxy about their goals and preferences, are central to person-centred high quality Anticipatory Care Planning (ACP).

3. **Documentation and sharing**
   Recording the outcomes of Anticipatory Care Planning (ACP) conversations and sharing them with those that need to know helps everyone understand the priorities for treatment and care. This helps to ensure that the right decisions are made at the right time.

4. **Regular review**
   An Anticipatory Care Plan (ACP) is a dynamic record that should be developed over time. It should be reviewed and updated as the individual's condition or personal circumstances change.

More information on ACP and all of the national tools available can be found at www.ihub.scot/acp.

Question 6: How is ACP information gathered and shared with GPs and other clinicians/practitioners?

There is no right way, or agreed way, to gather ACP information. This is completely down to those gathering the information and what is practical. It should be noted however, that it is important to remember that whichever method used to gather information, you **MUST** adhere to information governance rules within your organisation and your service.

Question 7: KIS special notes – do you note the locations of ACP/PoA here or do you pull out the key information from the ACP and record it here?

The special notes section of the Key Information Summary should be succinct, relevant and to the point. You do not need to note the location of the ACP here. This box is extremely useful for out of hour's services, Scottish Ambulance Service or NHS 24 for example, that may need to help a patient in an emergency but won't necessarily have access to the ACP. It is useful to think about what information they would need to know and to consider the limited amount of time they have to read it.

More information can be found in the Key Information Summary Guidance developed by HIS in collaboration with RCGP and Scottish Government.

Question 8: If I were to initiate and ACP, is there a paper copy to use and how does the GP know to add this to the KIS?

Yes, the GP should be informed if an ACP is initiated to ensure the KIS is updated. This can be done using whichever method of communication works for you, however it is important to ensure that appropriate consent has been sought where required.

There are a number of different tools that can be utilised to support the development of an ACP, each having their own merit within the appropriate setting. One particular tool would not be recommended over another.

More information on ACP, including a link to download a paper copy and all of the national tools available can be found at https://ihub.scot/acp.

Resources

Question 9: Is there a standardised ACP?

In short, no, there is no one standardised ACP. There are a number of different tools that can be utilised to support the development of an ACP, each having their own merit within the appropriate setting. One particular tool would not be recommended over another.

What is important to note however, is that the tool used is not as important as the conversation itself, for which there are 4 main steps:

1. **Preparation and Planning**
   This involves identifying who you will be having the ACP conversation with, then preparing yourself and the person for that conversation.

2. **Meaningful conversations**
   Meaningful conversations with an individual, their families and / or legal proxy about their goals and preferences, are central to person-centred high quality Anticipatory Care Planning (ACP).

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   Recording the outcomes of Anticipatory Care Planning (ACP) conversations and sharing them with those that need to know helps everyone understand the priorities for treatment and care. This helps to ensure that the right decisions are made at the right time.

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Medical

Question 10: At what stage should a patient be referred to the palliative care team?

What is very important to note is that a patients ACP is not owned by, or updated by, a particular team or specialty. Anyone can initiate and update an ACP. It is about that patient's journey and honouring their chosen options and plans for any future care. The ACP should follow the patient no matter what department they are being treated by.

In terms of when patients being referred to the palliative care team, we would refer you to the Palliative and end of life care: strategic framework for action for more information.

For more information on ACP in general, as well as some useful hints and tips please go to www.ihub.scot/acp.