

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.

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 wish to be admitted to hospital or prefer to receive treatment elsewhere if possible.

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.nhsggc.scot/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.nhsggc.scot/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).

Consent

- Explicit Consent has been removed
- If someone chooses to decline an ACP this is recorded on Clinical Portal. Please provide details including if/when the conversation could be revisited
- If there are any issues or things that need to be highlighted, add them in the "special notes" section e.g. if family are not to be told etc.

Next of Kin/ Carer Information

Remember to offer the carer a referral to carer support services. Refer via Carers Information Line - 0141 353 6594

Possible Other Agencies Involved

- Social work
- Pharmacy
- Local support
- Carers support services
- Palliative care services
- District nurses
- Hospice services

Preferred Place of Care/ Hospital Admission

- Current place of care and future wishes
- Escalation plans/potential triggers for change in care plan
- Family understanding of diagnosis, prognosis and treatment plan

Resuscitation

- Referral for DNACPR if required
- Location of DNACPR form
- Family agreement/ knowledge of DNACPR

Using the ACP Summary - what information to document.

We are sharing this information for routine patient care as part of our Board's duty to provide healthcare to our patients. Under article 6(1)(e) of the UKGDPR and in conjunction with the Intra NHS Scotland Sharing Accord, we do not require consent to share this information. However, it is best practice for staff to make sure the individual and/or their legal proxy is aware this information will be shared when conducting ACP conversations. If the patient would like further information about how the Board uses their data it can be found in our Privacy Notice here: <https://www.nhs.uk/gov.uk/patients-and-visitors/naqs/data-protection-privacy/#/>

Date of Review: _____ Date of Next Review: _____
 Reviewer: _____ HSCP/Directorate: _____ Job Family: _____

0. Reason for ACP and Special Notes
Reason for ACP (Please note, this is mandatory)
 Trigger for ACP: Patient Requested LTC Diagnosis/Progression
 /Update: Family/Carer/POA Requested Receiving Palliative Care
 (please select one): Professional Requested Moved to Residential/Nursing Home
 Frailty Score: Frailty Identified Other (please specify): _____

Please select Frailty Score* from list: 0 - Not Applicable
 *Clinical Frailty Scale Guidance can be found on last page.
 If frailty assessment is not applicable, please select "0 - Not Applicable".

Special Notes: What is important to the individual?
 Overview of person including family circumstances, accommodation information, health goals, what matters to them, emergency planning information etc. If person is a carer, or has informal carers please state. If person lacks capacity ensure this is recorded alongside who has been present during any discussions.

1. Demographics

Person's Details
 Title: _____ Gender: M F CHI: _____
 Forename (s): _____ Surname: _____
 Date of Birth: _____
 Address inc. Postcode: _____
 Tel No: _____
 Access information e.g. key safe: _____

GP/Practice details

GP/Practice Name: _____
 Address inc. postcode: _____
 Telephone No: _____

Next of Kin

Title: _____ Gender: M F Relationship: _____ Keyholder? Yes No
 Forename (s): _____ Surname: _____
 Address inc. Postcode: _____
 Tel No: _____ Is Next of Kin also Carer? Yes No

Carer

If staff have a duty to identify carers as soon as possible and inform them of their right to support. Carers can be referred to local Carer Support Services via the Carers Information Line 0141 353 6504 (carers can also self-refer if they wish). Find further information at www.nhs.uk/gov.uk/carers
 Title: _____ Gender: M F Relationship: _____ Keyholder? Yes No
 Forename (s): _____ Surname: _____
 Address inc. Postcode: _____
 Tel No: _____

Other Agencies Involved

Organisation / Main Contact: _____ Contact Numbers: _____

2. Summary of Clinical Management Plan/Current Situation

Current Health Problems/Significant Diagnoses
 Overview of health issues and diagnoses. Baseline functional and clinical status to help clinician identify deterioration - e.g. baseline O2%, 6-CIT score, level of mobility, current or planned treatments.

Essential Medication and Equipment	Yes	No	Notes
Oxygen therapy	<input type="checkbox"/>	<input type="checkbox"/>	
Anticipatory Medication At Home	<input type="checkbox"/>	<input type="checkbox"/>	
Continence / Catheter Equipment At Home	<input type="checkbox"/>	<input type="checkbox"/>	
Syringe Pump	<input type="checkbox"/>	<input type="checkbox"/>	
Moving and Handling Equipment At Home	<input type="checkbox"/>	<input type="checkbox"/>	
Mobility Equipment At Home	<input type="checkbox"/>	<input type="checkbox"/>	

3. Legal Powers

Adults with Incapacity / Legal Powers	Yes	No	Notes e.g. Guardian's details, date of appointment
Does the individual have a Combined Power of Attorney (financial and welfare)?	<input type="checkbox"/>	<input type="checkbox"/>	
Does the individual have a Continuing Power of Attorney (finance and property)?	<input type="checkbox"/>	<input type="checkbox"/>	
Does the individual have a Welfare Power of Attorney (health and/or personal welfare)?	<input type="checkbox"/>	<input type="checkbox"/>	
Is Power of Attorney in use?	<input type="checkbox"/>	<input type="checkbox"/>	
Is an Advanced Directive in place (living will)?	<input type="checkbox"/>	<input type="checkbox"/>	
Is an Adult with Incapacity Section 47 held?	<input type="checkbox"/>	<input type="checkbox"/>	
Has a Guardianship been appointed under the Adults with Incapacity (Scotland) Act 2000?	<input type="checkbox"/>	<input type="checkbox"/>	

Power of Attorney or Guardianship Details

Title: _____ Gender: M F Relationship: _____ Keyholder? Yes No
 Forename (s): _____ Surname: _____
 Address inc. Postcode: _____
 Tel No: _____ Notes e.g. if process is in progress, where paperwork is located etc.
 Date of Appointment: _____
 Paperwork Verified by Professional: Yes No
 Date Verified: _____
 Name of Verifier: _____

4. Resuscitation & Preferred Place of Care

My preferred place of care
 Depending on the person's own circumstances and health journey, this may include preference about long term care, place of treatment or place of death. Details of current level of care being provided by informal carers and/or any discussions which have occurred regarding on going and future care they might be able to provide.

My views about hospital admission/views about treatment and interventions/family agreement
 Where possible please give details regarding hospital admissions in different scenarios. For example, people may be willing to be admitted for a short period for symptom management, however would be unwilling to be admitted if it was likely they would be in hospital for long periods.

Resuscitation

Whilst these conversations can be helpful to plan future care, they should be held sensitively and appropriately. They are not mandatory. Comments: _____
 Has DNACPR been discussed? Yes No
 If YES, is a DNACPR Form in place? Yes No
 If YES, where is the documentation kept in the home? _____
 Refer to GP for further discussion re DNACPR? Yes No

Trigger for ACP/Update

- Record trigger for discussion

Frailty Score

- Consider a Rockwood frailty assessment. If not applicable select "0"

Special Notes

- What matters to the person e.g. motivations and health goals, faith or cultural aspects that are important
- Family situation inc. understanding and involvement in decisions, if they have a caring role for someone else etc.
- Accommodation situation inc. accessibility for equipment e.g. stretcher, key safe details, adaptations e.g. stairlift
- Possible risks/ difficulties e.g. pets, family dynamics, psychological states
- Preferred names
- Other care plans available
- Communication needs

Clinical Notes

- Main diagnosis/ prognosis
- Allergies
- Current medication
- Access to medication and equipment
- Level of mobility/ functionality
- Assessed capacity
- MUST/NEWS scores (if applicable)
- History of falls

Legal Information

- Power of Attorney
- Guardianship
- Adults with Incapacity

Remember
 Depending on your role and relationship, you may only know some of this information. Please input as much information as you can. Your colleagues will also be adding to this form.