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Dear Colleagues

Anticipatory Care Planning – Documents and Workload – Further Information for GP's

Work is continuing to raise the profile of ACP and support a more consistent approach towards anticipatory care across Scotland. This is in line with current national strategic direction outlined in Realistic Medicine and also recognises that a great deal of good work is already in place with professionals actively prioritising an ACP approach.

Practices received an initial supply of the "My ACP" documents in the summer. The response to these documents, which have been drawn from existing good practice across Scotland, has been generally positive. However, it's important to recognise and respond to a number of issues raised by GPs.

This letter acknowledges and discusses the main concerns that have been expressed about the document length and GP capacity to support the work, as well as clarification of ownership of the document and expectation of the number of ACPs that a practice should complete.

Is the "My ACP" document too long?

It's worth noting that the national ACP document was produced following extensive consultation with professionals, including many GPs, across the country. There was strong consensus that it was important to produce a single comprehensive document rather than several smaller papers.

The length of the complete document has caused some concern. However, it's important to highlight that "My ACP" covers a wide range of areas across different stages of the patient journey that will not be universally applicable but aiming to both prompt and improve patient awareness of important issues around personal preferences, Power of Attorney, Capacity and End of Life discussions.

It's not expected that it should be completed at one sitting. Instead the ACP should be an evolving document that complements and enhances continuity of care.

While practices have been used as distribution points for documents the clear intention is that these can be used by all professionals to support conversations or introduce the concept of ACP. This includes community nursing, social services and local third sector organisations. Much of the document can be completed by the individual although it is recognised that will very much depend on the individual and their specific circumstances.

How are GPs going to find the time to do this?

Managing more people with complex needs is becoming increasingly commonplace in General Practice as the population ages. Indications are the GMS Contract will evolve to recognise the increasing role of GPs in managing complexity. The ACP material is a tool that can support managing complexity.

It is also important to highlight that anticipatory care planning should be a whole system approach in line with the "ACP is Everybody's Business" message. Key to this principle is ACP being an evolving process, with many individuals from different professional backgrounds supporting people with complex needs who can contribute to developing the plan. There are also training and education needs to be met to enable this to happen routinely.

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It is a reality that initial ACP conversations do take time. However, as GPs we are faced with that situation just now in practice and ACP can be used as a way of helping people make informed decisions, avoiding duplication of work and reducing avoidable contacts in future.

Is there a target for GPs and the number of ACPs completed?

No. The important priority is to engage with GPs to understand and to gain GPs support for the principles of ACP.

The initial communication to practices highlighted that it is estimated that 5-6% of the population have a complexity of need which would benefit from them having an anticipatory care plan. That figure was quoted for information and not to be interpreted as a target. However, it is understandable after years of QOF if some practices considered that was what was being asked.

The 5-6% roughly equates to the number of individuals outlined in the High Health Gain dataset but again there is no expectation that all these people require an ACP to be set up within a specific time frame. Practices are encouraged to think about who would benefit from ACP most. Quality of Anticipatory Care Planning and conversations is a much higher priority than the quantity of Anticipatory Care Plans. This is the same principle that is being applied to completion of the Key Information Summary. The ACP document has a summary page at the back which is hoped to be of use in improving quality of KIS.

Who owns the document?

The document (or App) should be owned and kept by the individual to share with as appropriate. As an alternative to the paper documentation the **My ACP- Let's Think Ahead** App has been developed for android and iOS devices and is available to download from the App Store.

Additional supplies of documents

While stocks last, you can order the **"My Anticipatory Care Plan - Let's think ahead"** documents free of charge. Please email your order along with your delivery address to hcis.livingwell@nhs.net.

An agreed process for practices to order locally through Board areas is currently being investigated for the future.

We are happy to receive and discuss any comments or considerations about the documents, or broader issues relating to ACP. Please contact the Living Well in Communities team at hcis.livingwell@nhs.net.

Yours sincerely,

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