The Mid Yorkshire Hospitals NHS Trust

wakefield hospice SHARING THE CARE

NHS Wakefield Clinical Commissioning Group

Advance Care Planning

Multi-Professional Education & Training Project

End of Project Report

March 2014 - August 2015

Authors:

Jan Walker & Marian Oakhill

Contents **Page**

1. INTRODUCTION

This report sets out to highlight the achievements of Advance Care Planning (ACP) training undertaken, discuss the challenges which the project overcame, and demonstrate the approach taken to engage with health professionals across the health economy in Wakefield and the district and make recommendations for sustainability.

2. SUMMARY

Ring fenced money for multi professional education and training has enabled Mid Yorkshire hospitals and community teams to benefit from a wide variety of training methods to embed the principles and practice of Advance Care Planning with patients within everyday practice. Having dedicated trainers who could respond to clinical teams, delivering training at the work place in a time and place to suit and be adaptable to their needs has ensured a wide range of staff have been trained to levels appropriate to their role. Ongoing training in end of life care has been identified as a priority by many of the teams and the project reinforces the need for dedicated posts to deliver this.

The project had clear aims and objectives and was continually monitored and evaluated. We used a clear methodical approach to the delivery of education, made possible by having no clinical responsibilities. Our clinical expertise was utilised to support the challenges and achievements.

This project was undertaken at time when there were huge demands on service delivery, especially staffing shortages within the acute setting which appears evident in the numbers trained compared to community services.

Partnership with the Electronic Palliative Care Co-ordination System (EPaCCS) project proved beneficial especially as ACP is essential for effective record keeping in the EPaCCS template.

3. BACKGROUND

This project has been funded by Health Education Yorkshire and the Humber (HEYH). In 2011 providers within the region were encouraged to submit a bid for these national funds via HEYH for local clinical education projects. Within this region Advance Care Planning education and training was identified as an area of need by HEYH. The Mid Yorkshire Palliative Care Education Forum identified ACP as a priority in their Strategy for 2011-2015.

Wakefield is an industrial city within West Yorkshire, a largely white British ex-mining community with a population of 306,521. Mid Yorkshire Hospitals NHS Trust manages 3 hospitals within the district and all the community nursing services, and there are 40 GP practices within Wakefield CCG.

Communication lies at the heart of health care delivery. Advance Care Planning (ACP) is a voluntary process of discussion and review to help an individual who has capacity to anticipate how their condition may affect them in the future and, if they wish, put this on record regarding their choices about their care and treatment.

(NHS End of Life Care Strategy, 2008)

4. AIMS OF PROJECT

To implement a district wide training and education programme to practice based clinical teams including Mid Yorkshire Hospitals, Wakefield District Community Nursing and Wakefield GP Practices with regard to ACP.

Objectives:

- Develop training materials for ACP
- Design audience appropriate training packages
- Deliver training in various venues and in various ways
- Target appropriate clinical teams
- Survey staff pre and post implementation
- Collect and monitor identified data
- Report to the steering group bi-monthly
- Raise the profile of ACP for generalist health professionals in Wakefield
- Improve patient care and experience

Benefits Expected:

- Increase the % of patients who die in their preferred place of care / death
- Improve anticipatory prescribing for symptom control
- Reduce inappropriate investigations and treatments
- Reduce inappropriate hospital admissions
- Reduce bereavement associated problems
- Enhance staff skill, knowledge, confidence and competence
- Increase the number of patients with an ACP

Benefits for key Stakeholders:

- Patients are at the centre of discussions and decision making
- Care is delivered in the most appropriate setting for the patient
- Empowered communities, service users, families and friends
- Support for the implementation of the EPaCCS project
- Appropriate access for patients to specialist services
- Staff are well motivated and trained to deal with ACP and consequential issues
- Promotion of End of Life Care discussions amongst staff and the public

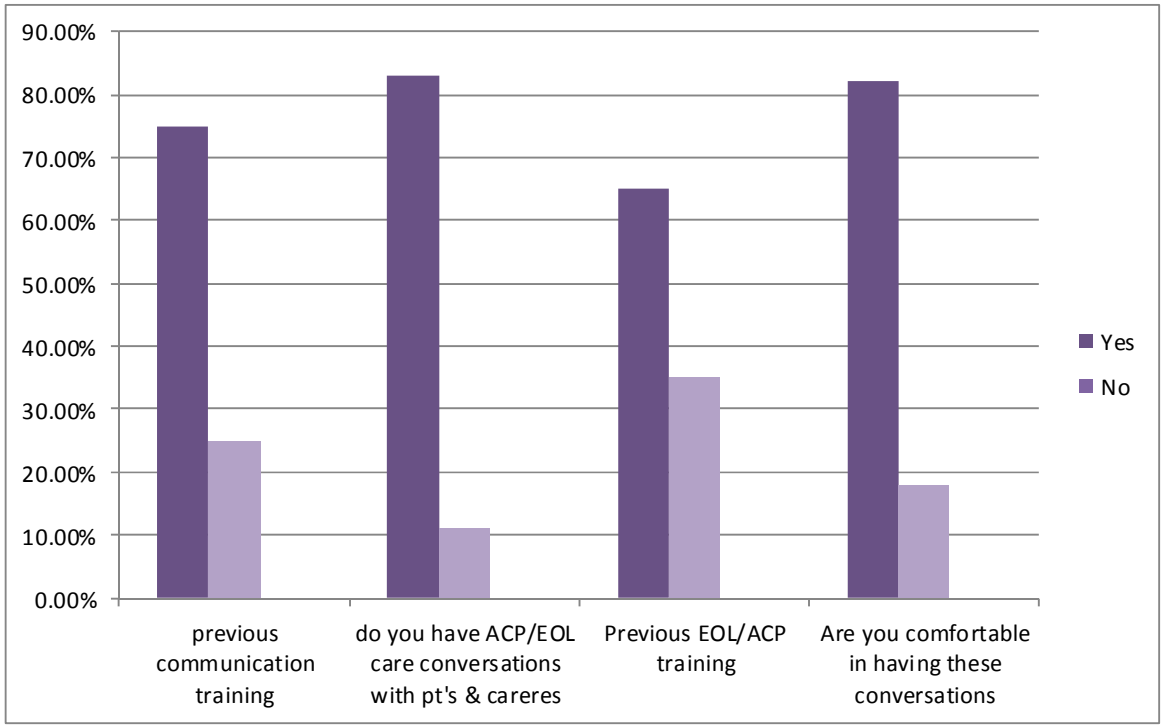
5. METHOD OF DELIVERY

Two End of Life Care Education Facilitators (1.60 wte) were employed for 18 months. They were supported by a Macmillan Consultant in Palliative Medicine and a GP, End of Life Care Lead. There had been a decision to use the Preferred Priorities for Care document to record ACP wishes within the Trust 5 years previously, but there was little uptake of this at the start of the project**.**

Initially it was important to build relationships with significant people within the Trust to ensure senior management were aware of the project. We had contact meetings with an Associate Director of Nursing, Division of Medicine and the Interim Deputy of Nursing Care Closer to Home. Then we approached the ward sisters on the target wards identified by the project team and the community nursing team leaders, community practice educators and the GPs directly. On implementation of this project there were no practice educators within the hospitals. We advertised in bulletins and newsletters via the Clinical Commissioning Group (CCG) and the Trust. We utilised opportunities to train groups and specialist teams as they arose.

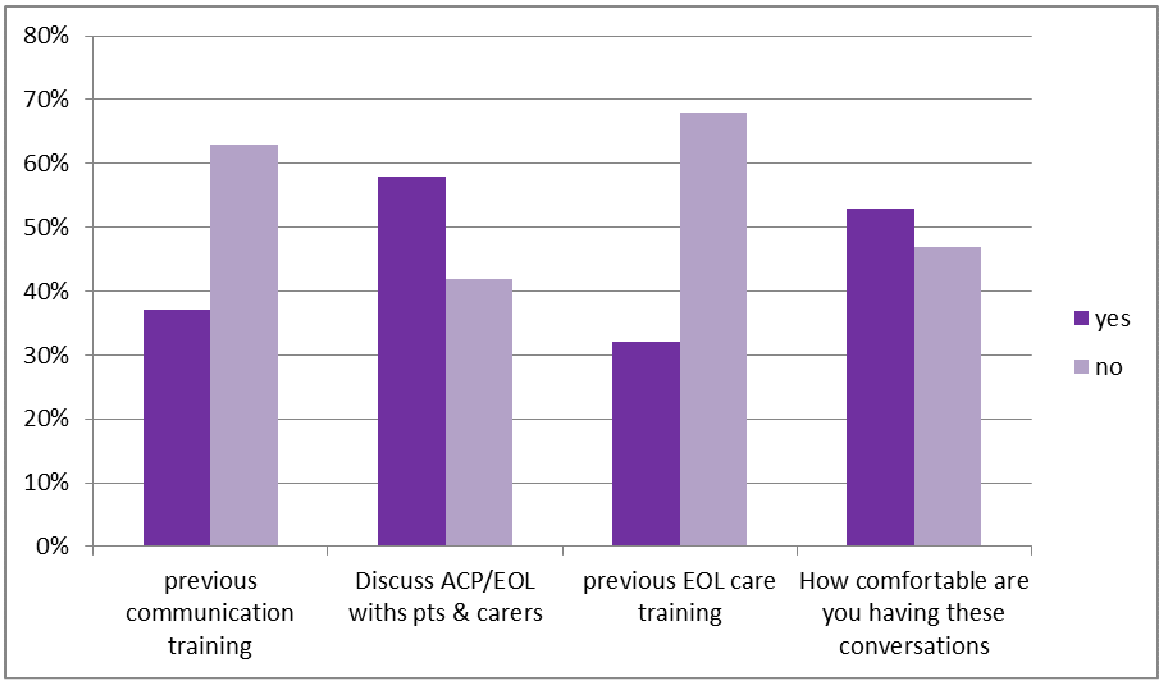
We devised a Project Initiation Document (**Appendix 1**). We met with Organisational Development and linked our training with their department. We devised a Survey Monkey but this had a poor take up despite advertising in the Trust bulletin. We therefore, for a two month period, asked our delegates to complete a pre training survey **(Appendix 2**).This identified that **65%** of respondents had received ACP training previously but only **18%** implemented this in practice.

ACP & Communication training; Survey of community based staff



Prior to training on the wards we asked staff to complete a questionnaire, the table below demonstrates that while **68%** of the hospital staff on the target wards, who are dealing with EOLC patients, have not had any training in the care of these patients, yet **53%** felt comfortable discussing EOLC issues with patients and families.

ACP & Communication training; Survey of hospital based staff



In March 2014, a sample audit of hospital notes from discharges on 4 care of the elderly and medical wards at MYHT identified that discharge letters contained no information at all about any advance care planning decisions/discussions in patients where these conversations would have been appropriate and relevant. In primary care only **2.5%** of patients on practices' End of Life Care registers had an advance care plan recorded (**Appendix 3**).

We networked across the region and joined the Yorkshire and Humber Regional End of Life Care Education Facilitators group which helped us learn from their experiences and share their resources. Devising training plans and packages which were flexible in delivery, method and time was essential in order to respond to the diverse groups and environments.

Types of training provided:

- Whole day "Train the Trainer" workshops
- Half day communication workshops
- One hour interactive training in GP practices
- Clinical team 1-2 hour workshops
- 30 minutes drop in sessions on wards
- Education stands
- Shared training events for GPs / consultants / junior doctors

We determined that ongoing evaluation of training and training methods was important and reports were produced, consequentially the programmes were adjusted in response. People attending the "Train the Trainer" programme were predominantly senior nurses and the pre-training questionnaire (**Appendix 4**) identified that they had awareness of what ACP was and predominantly felt moderately confident in starting a conversation about End of Life Care (EOLC) issues. They felt that they talked to their patients about these issues, **60%** at least twice a week. Also they identified that it was the reluctance of relatives to have these conversations that prevented discussing EOLC issues with patients.

We bought a game following a workshop at national conference in London, (Circle of Life, End of Life Care Board Game, NHS Gloucestershire CCG) which we found very effective and the trainees really enjoyed. The game was really interactive and created debate around ACP. There are four categories: ACP, policies, communication, and best interest decisions. We also devised an Alternative Pub Quiz which was so well evaluated we were able to deliver this at a national event and share regionally.

6. PROJECT CONTROLS

This project is responsible to The Mid Yorkshire Palliative Care Education Forum and the Facilitators produced bi-monthly reports which were shared via the forum (**an example - Appendix 5**). Throughout the project data has been collected regarding the groups and numbers taught and any evidence of how the training changed practice.

7. ACHIEVEMENTS

Currently we have trained over **900** staff with further training arranged. We were able to do this by engaging with staff at all levels, and helped them identify what skills they have or may need to implement ACP discussions in their practice. We used patient scenarios to explore the issues and we also provided communication training. Through a training evaluation report (**Appendix 6**) we identified that it was appropriate, valuable, and the mixed groups generated richer discussions. This is evident from the comments received which also shows the staff felt more knowledgeable, confident and competent (**Appendix 7**).

Our 'Alternative Pub Quiz' and our rapport as presenters evaluated so well at the National Council for Palliative Care (NCPC) national conference, regional colleagues requested that we share our training materials for all to use. We were asked to submit a case study to National Health Service Improving Quality (NHSIQ) after this event. We will be writing a report for the NCPC journal 'Inside Palliative Care' at the request of Clare Henry, Chief Executive.

In line with the project objectives appropriate clinical teams were identified, contacted and training was delivered to the areas that responded. We often trained mixed groups but overall **85.3%** of GPs and **62.2% (Table 1)** of community nursing service staff have been trained. These staff groups were easier to access due to the nature of their working patterns compared with the acute hospital staff groups. GPs repeatedly requested further training in all aspects of end of life care. We took every opportunity to deliver at local and regional events and trained a total of **176** staff from our Trust in this way **(Table 2)** raising the profile of ACP for generalist health professionals. This data is correct as of May 2015 and future training is planned for all groups until project end date 3rd September 2015.

Table 1

	Numbers	Numbers trained	% trained
GPs	278	237	85.3%
Community nurses	366	228	62.2%

Table 2

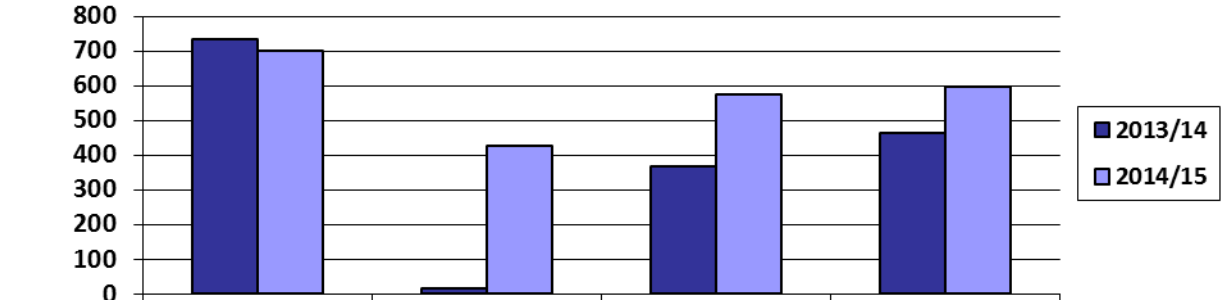
Events	Numbers trained
DNACPR study day	38
Macmillan conference	29
Building connections NCPC conference	40
PC & EOLC workshop	32
MND study day	10
Hospice staff	17
Age UK	10
Total	**176**

Post training we audited the ward areas where training had been delivered. **60%** now have the recognised ACP documentation on display. Also a clinical nurse specialist team now incorporate ACP in their assessment process in the outpatient department. A community pharmacist has been able facilitate this process for patients in the community with positive outcomes.

This project worked in conjunction with the introduction of the Electronic Palliative Care Coordination System (EPaCCS) across the Wakefield district. This helped us identify data in regard to ACP within the community. This data suggests a significant improvement in ACP within the area (**Appendix 8**). In particular in quarter 2 of the project, the numbers of patients with an ACP peaked whilst we were providing training to community services.

The Pre and Post data collection graph clearly demonstrates the improvements made and that ACP is now being implemented in practice.

Pre and Post data collection



	total deaths	ACP recorded	PPD recorded	DNACPR
2013/14	733	18	366	462
2014/15	700	428	573	597

8. CHALLENGES

Understanding the hospital structure initially was difficult as there was no structural map available and the intranet did not provide this information. The senior nurse structure was under constant reorganisation therefore contacts given repeatedly changed roles and were no longer responsible for that clinical area.

Utilising local contacts we were able to make inroads into the hospitals and eventually decided to be proactive and introduced ourselves to the ward sisters and arranged training. During this period it has to be recognised that there were shortages of staff in all of the clinical areas, with frequent movement of staff between wards and departments and many of these were new to the Trust. Due to the 12 hour nursing shifts there was also no overlap of staff during the day. Therefore though all the staff we met were keen to receive training, at all levels, the opportunity to release staff, though pre-planned, was very limited.

All wards identified the best time to release staff was between 13.30 - 14.30, therefore it limited how many wards we could attend at one time It was also identified by the ward sisters that 10 minute sessions were not a sufficient or effective learning experience for their staff, so 30 minutes was agreed. We attended the wards **73 times**, staff were released on **17 occasions** and a total of **71 staff** were trained. To highlight the issues to senior management we compiled a report (**Appendix 9**). During these sessions we highlighted the Nursing Assessment document, used for all admissions, in particular Section 13 End of Life Planning, which no members of staff we trained completed.

Service demand prevented staff within the trust being released from clinical areas and therefore ward based training and planned half and full days had to be cancelled. This was compounded by low staffing levels and recruitment issues. This is highlighted in the numbers trained in the hospital setting (**Table 3**) compared with community services. Therefore during this period we concentrated on training specialist teams and GP practices.

It was difficult to engage and co-ordinate training with the members of the Trust's Specialist Palliative Care Nursing team which unfortunately allowed opportunities of joint training and other initiatives to be missed as in the case of the introduction of a new Care Plan for Dying Patients.

Connectivity and IT systems continued to be a challenge throughout the project, connections being slow and often very difficult to access. This was a constant irritation along with a limited access to venues which were often booked well in advance by others and not utilised.

Certain teams have not engaged with the project, despite repeated contact, some perceiving ACP not being appropriate for their client groups, so perseverance has been our bye word.

The regional Preferred Priorities for Care document was often not well received by clinicians. We had frequent negative comments regarding the content of this document.

Table 3

	Numbers trained in acute hospital
Consultants	27
Other doctors	80
Senior nurses	37
Nurses	83
Other	2
TOTAL	**229**

9. DISCUSSION

Having the opportunity to be involved in an 18 month project to deliver ACP has been a really positive experience. Utilising our skills in specialist palliative care and teaching, we have embraced the challenges both in the classroom and in clinical settings to discuss the dilemmas and the constraints clinical teams face when introducing ACP in practice.

We were received well by community services, both GP practices and district nursing teams, which is evident in the numbers trained. Mixed group training events were the most animated, generating interesting debates, sharing experience and concerns and making ACP “Everybody’s Business”.

We have trained significantly more staff in the community, but it was very evident that staff in the acute setting were keen and enthusiastic to have the training especially as they had very little knowledge about ACP. Their evaluation comments requested more training, longer sessions and larger group work as they enjoyed “other people’s opinions”. Unfortunately the implementation was challenged by staffing levels therefore we were only able to train small numbers within the acute settings. We feel this could have been improved if stability and communication with senior nurses within the Trust had been easier.

The full and half day training events evaluated really well, staff felt that this would be the most effective way for them to access training. They also felt that they had learnt a great deal and really benefitted from networking with staff from other areas. Unfortunately once again numbers were low due to increased pressures within the hospital and staff who did attend often came on their day off.

This project was separate from the specialist palliative care services working within this area, and remained so throughout, which allowed greater breadth of flexibility for training opportunities both for audience and venues, and alleviated the pressures of delivering education whilst still having clinical responsibility. Fortunately it took place alongside the introduction of the EPaCCS which enabled both projects to work in collaboration together.

The high service demand brought new challenges, we were able to arrange and train other specialist teams within the hospitals and GP practices who welcomed the training and frequently requested more training on the wider issues of palliation. We also delivered a workshop at a national conference. Education stands were set up and manned in the staff restaurants across the 3 sites but unfortunately they were not well received, staff did not welcome this on their well-earned break.

We are currently delivering training across the Trust and hoping to target more community nursing teams, hospital wards and specialist teams. Alternative ways of getting the message across include designing a poster for all clinical areas.

The data would suggest that by having a continuous dedicated approach to training ACP, clinical staff have engaged with patients who are approaching the end of life phase, which has enabled them make choices, discuss and plan their future care. This is supported by the EPaCCS data, in the year prior to our training in March 2013 - April 2014, **2.5%** of people who have died had ACP recorded, compared with March 2014 – April 2015 **61%** people had ACP recorded.

10. KEY RECOMMENDATIONS

- There should be dedicated End of Life Care Educationalists (with no clinical responsibilities) on a permanent basis.
- ACP/EOLC training should be essential to role for all staff who care for patients with a life limiting condition.
- Staff benefit by being released from their clinical areas to receive training where they have the opportunity to share experience with staff from other clinical areas.
- ACP documentation should be available throughout the hospital and community Trust (Preferred Priorities for Care/regionally recognised document).
- Preferred Priorities for Care document needs a comprehensive review (last revised 2007).
- Any patient who has given permission to be on the Electronic Palliative Care Coordination System (EPaCCS) is identified on admission, utilising the icon on SystmOne boards in clinical areas.
- Any ACP discussions should be clearly documented in the patients' notes and on the discharge letter from hospital (EPaCCS if accessible).
- Discharge letters should contain information regarding ACP including the completion of DNACPR documents (We have requested that this is added to the SystmOne discharge letter).
- Review of section 13 of the Hospital Nursing Assessment Document.

11. APPENDICES

CONTENTS

Project Initiation Document
And Implementation Plan

Project:	Advance Care Planning Education and Training Programme
Date:	March 2014
Author:	Marian Oakhill and Jan Walker
Project Manager:	Marian Oakhill and Jan Walker
Sponsor:	Health Education England MPET (Multi Professional Education and Training)

Project Initiation Document History

Document Location
This document is only valid on the day it was printed

The source of the document will be found on the project's shared folder
Location……..

Revised History

Revision Date	Summary of Changes
14/04/14	Complete domains
28/05/14	Comments included

Approvals

This document requires the following approvals

Name	Signature	Project Role
Joy Waldock		Sponsor

Distribution

This document has been distributed to:

Name	Project Role	Date Distributed
Joy Waldock	Macmillan Consultant in Palliative Medicine, (Lead)	05/05/14
Lynda Wright	GP EOLC Lead	05/05/14

Contents

PURPOSE OF THE DOCUMENT

The purpose of this document is to define the project to form the basis for its management and the assessment of overall success.

This document will outline:

- Agreed deliverable and associated benefits
- Agreed levels of accountability
- Associated risks

BACKGROUND

This project has been funded by Health Education Yorkshire and the Humber (HEYH).
In 2011 providers within the region were encouraged to submit a bid for these national funds via HEYH for local clinical education projects. Within this region Advance Care Planning education and training was identified as an area of need following a training need analysis of health professionals undertaken by HEYH.

Communication lies at the heart of health care delivery. Advance Care Planning (ACP) is a voluntary process of discussion and review to help an individual who has capacity to anticipate how their condition may affect them in the future and, if they wish, put this on record regarding their choices about their care and treatment.

(NHS End of Life Care Strategy, 2008)

PROJECT DEFINITION

Project Objectives and Expected Benefits

Aim: To implement a district wide training and education programme to practice based clinical teams including Mid Yorkshire Hospitals, Wakefield District Community and Wakefield GP Practices with regard to ACP.

Objectives:

- Develop training materials for ACP
- Design audience appropriate training packages
- Deliver training in various venues and in various ways
- Target appropriate clinical teams
- Survey staff pre and post implementation
- Collect and monitor identified data
- Report to the steering group bi-monthly
- Raise the profile of ACP for generalist health professionals in Wakefield
- Improve patient care and experience

Benefits Expected:

- Increase the % of patients who die in their preferred place of care/ death
- Improve anticipatory prescribing for symptom control
- Reduce inappropriate investigations and treatments
- Reduce inappropriate hospital admissions
- Reduce bereavement associated problems
- Enhance staff skill, knowledge, confidence and competence
- Increase the number of patients with an ACP

Benefit Key Stakeholders:

- Patients are at the centre of discussions and decision making
- Care being delivered in the most appropriate setting for the patient
- Empowered communities, service users, families and friends
- Support the implementation of the Electronic Palliative Care Co-ordination System (EPaCCS) project
- Appropriate access for patients to specialist services
- Staff are well motivated and trained to deal with ACP and consequential issues
- Promote End of Life Care discussions amongst staff and the public

Defined Method of Approach

The End of Life Care facilitators report to a steering group bi-monthly. The steering group, the Mid Yorkshire Palliative Care Education Forum, identified the need for ACP training in their Mid Yorkshire District Palliative and End of Life Care Education Strategy 2011-2015.

The chair of the steering group reports to the HEYH who act as the project board.

Due to the short time scales, 18 months, intensive planning and networking will be undertaken at the early stages of the project, followed by regular defined monitoring and reporting cycles.

The project will be utilising national and locally approved supporting documentation/ tools to facilitate a seamless increase in adoption of ACP discussions and process.

Project Scope

To deliver ACP training and education to clinical teams in Mid Yorkshire Hospitals, Wakefield District Community and Wakefield GP practices by September 2015.

Project Exclusions

The project does not include clinicians from children's services, but these would not be excluded from open training sessions.

Constraints:

- Engagement from Consultants and Senior Nurses within the hospitals
- Reliance on clinicians to be motivated to attend training
- Reliance on staff to be released for training
- Time constraints in clinical areas
- Shortages of clinical staff/ nurses to cover clinical areas
- Availability of suitable venues for training
- Engagement of staff as Champions to maintain sustainability of training
- Timescale of project

Dependencies

Partnership working with senior clinicians, GP's and managers, to facilitate training opportunities for staff.

Interfaces with other Projects

This project will run concurrently with the EPaCCS project which was launched on 01 April 2014. These projects link with one another and when appropriate will deliver training together. Both projects are designed to facilitate seamless and personalised care for patients with life limiting conditions.

ROLES

Project Steering Group

Key Responsibilities:

- Identify a medical lead as a core member of the project steering group
- Report to HEYH on progress of project
- Ensure efficient and effective use of resources
- Ensure project remains within financial envelope

Project Sponsor

Key Responsibilities:

- Ultimately responsible for successful delivery of projects objectives

Project Medical Support (Macmillan Consultant in Palliative Medicine & GP Lead for End of Life Care)

Key Responsibilities:

- Liaise and meet as agreed and appropriate
- Support and advise design and development of training packages

- Deliver training and presentations with the End of Life Care Education Facilitators, when appropriate

End of Life Care Education Facilitators

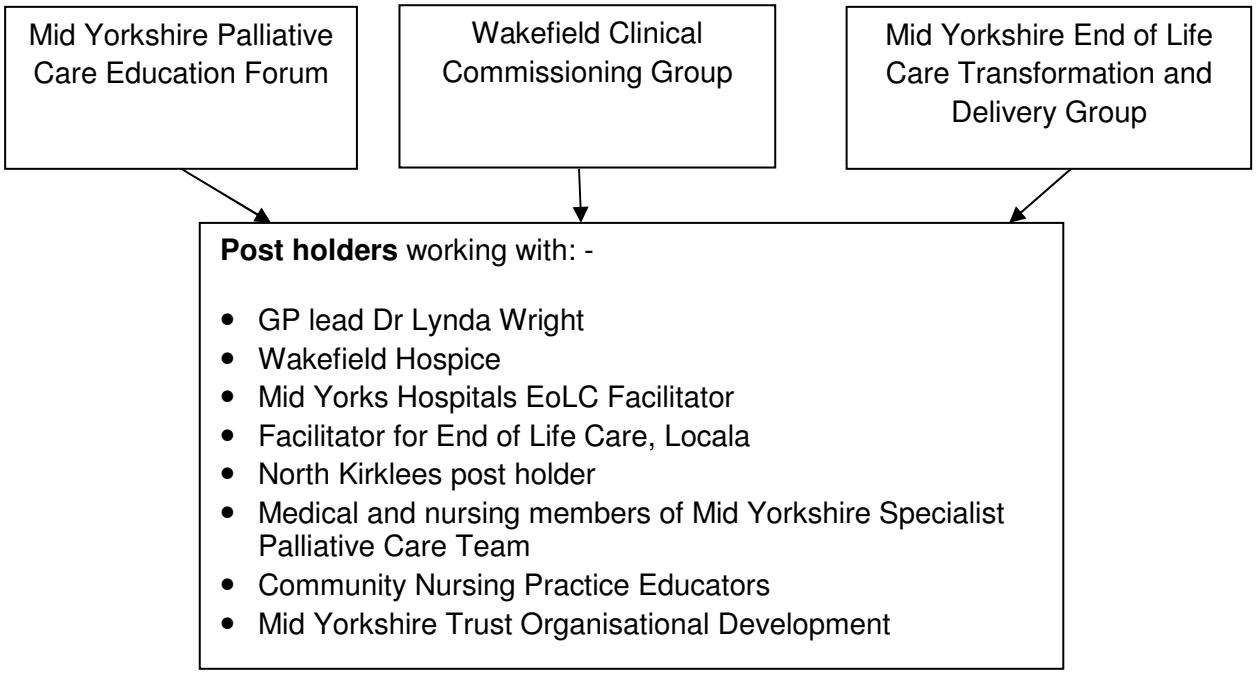
Key Responsibilities:

- To deliver education and training to target professional groups
- Design and develop training materials and packages
- Collect and collate data specified by project design
- Develop and implement pre and post questionnaires for staff
- Develop a marketing strategy
- Ensure a regional approach to ACP

PROJECT ORGANISATION STRUCTURE

KEY RELATIONSHIPS

- Consultants, junior doctors and GPs
- Primary Health Care Teams
- Clinical Nurse Specialists
- Senior Managers
- Hospices
- Multi-disciplinary ward based staff
- Matrons in community and hospital
- Care Homes
- Patients / Carers
- Resuscitation training officers



PROJECT COSTS

Quality Plan:

Planned quality assurance activities include:

- Review and establish regional strategies for training ACP
- Ensure national and regional materials for ACP are utilised
- Design and develop training packages approved by the medical and GP leads supporting the project.
- Develop a training plan

Project Controls

This will be exercised throughout the project by the End of Life Care Facilitators reporting to the steering group, by-monthly and collecting and monitoring data regularly.

Project Plan

Appendix 1

[Appendix 1]

ADVANCE CARE PLANNING PROJECT PLAN
Jan Walker / Marian Oakhill
End of Life Care Education Facilitators
2014/2015

Objective	Task	Success Criteria	Timescale
Hospital and Community Awareness of Project	Network across region, to engage with clinical leads and service delivery agents. Establishing Links across region. Establish links within the hospitals and community.	Meetings arranged with key clinicians and services across community , hospices and hospitals	June 2014
Training Packages	Development of appropriate materials	A selection of training materials, time and staff grade appropriate	June 2014
Delivery of multidisciplinary Training	Work with GP lead Dr Lynda Wright and Consultant Lead for Palliative Care Education Joy Waldock.	Education and training delivered in various venues and settings, ensuring a high standard and equity of access for clinical staff.	To end of project; Sept 2015
Establish were services are now	Questionnaire Gathering currant data	Establish a data base of • No. Deaths on target wards • No. Deaths caseloads • No. Deaths on practice lists. • No of PPC recorded • No. of PPD recorded • NO. pts with ACP • Case mix on Registers • No of DNACPR forms completed • Staff receiving training	Jun 2014
Report to Steering Group	Progress report.		Bi monthly
Progress reports of project effectiveness.	Number of people Trained CQUINs		Final report Aug 2015
Governance	Training that is delivered is, currant, relevant, appropriate and meets national standards. Develop an infrastructure to support project.	Establish a change in practice. Project plan. Implementation Strategy	Ongoing
Finance	Keep within budget		Ongoing

Advance Care Planning Survey
Of Community Based Staff
June / July 2014

Purpose of Survey:

To establish knowledge base and practice of Advance Care Planning (ACP) in the Mid Yorkshire NHS Community Services.

Authors: Jan Walker & Marian Oakhill

Background:

This survey was undertaken as part of an 18 month project to train both hospital and community professionals with regard to ACP. This project is funded by Health Education Yorkshire and Humber who identified ACP as a key area of need. This survey (paper version 1) was undertaken 4 months after the project commenced.

Method:

A questionnaire was designed and supported by two End of Life Care (EOLC) Education Facilitators, a Consultant in Palliative Medicine and a GP EOLC Lead.

It was given to community staff (28) prior to training to complete, anonymously.

The results were evaluated and reported by the EOLC Education Facilitators.

Survey Results:

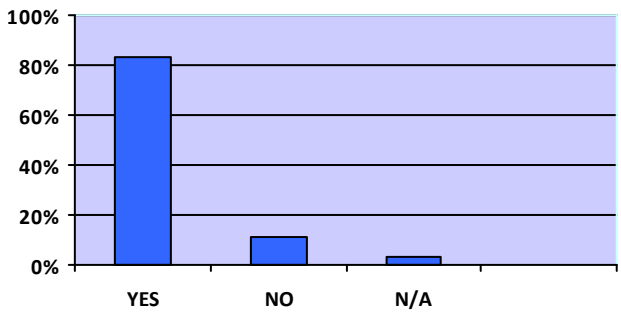
Question:

1. Staff Group:
90% were nurses 3% HCA 7% student nurses

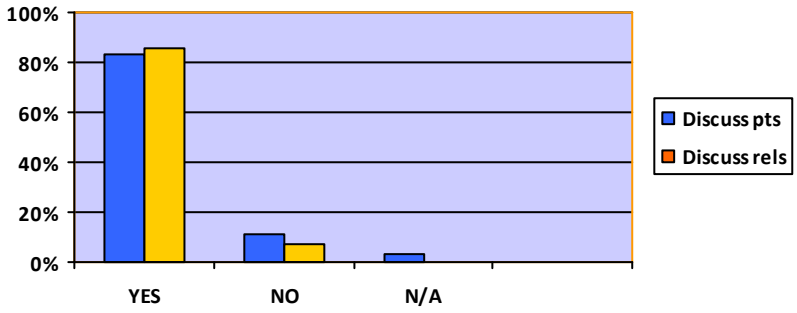
2. Previous training in EOLC:
74% stated Yes 25% No

3. Previous training in Communication Skills:
65% stated Yes 32% No

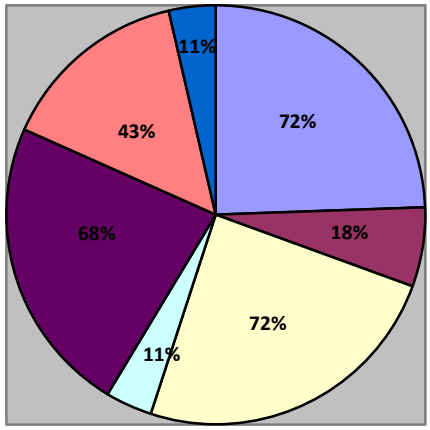
4. Do you discuss EOLC / ACP issues with patients?
Yes 83% No 11% N/A 3%



5. Do you discuss EOLC / ACP issues with family / carers / loved ones of patients?: 86% Yes , 7% No



6. Which documents do you use to support these discussions?



Care Plan	72%
Advance Statement	18%
PPC/D	72%
ADRT	11%
DNACPR	68%
Discharge L/S	43%
LPA	11%

7. How comfortable do you feel about having EOLC / ACP discussions?

- Not Comfortable 14%
- Comfortable 50%
- Very Comfortable 32%

Findings:

- 28 staff completed the survey, 2 (7%) did not complete all questions.
- 4 staff (14%) did not identify that they used any supporting documentation though they undertook discussions with patients and family.
- The student nurses identified they had received training in EOLC / ACP.
- There was a higher proportion of staff that had received EOLC training than Communication training previously.

- Of those who had identified they had had no training in EOLC, 22% talk to patients and 25% talk to family about EOLC / ACP issues.
- Those who identified they had no Communication training felt they were Comfortable 25% or Very Comfortable 7% talking to patients about EOLC / ACP issues.

Respondents Comments:

- ACP, it's not always appropriate at first visit
- Effective communication for all EOLC is significant for all staff
- If appropriate to patient, it is good to plan future, however difficult when patients relatives (a) are not aware of patients diagnosis / prognosis, or (b) not wanting to discuss diagnosis / prognosis
- Would like training / relevant skills

Discussion:

This study identifies that a high proportion (74%) of community staff have received EOLC education in the past. The type and level of education has not been identified in the survey.

It has also identified that 65% of staff have received ACP training. Though they have received training only 18% of respondents implement ACP.

ACP is a process and a vital component of the process is good communication, therefore it is important to recognise the majority of this community based survey respondents felt they were comfortable 50%(14) and very comfortable 32%(9).

It could be argued that those who have received no training in EOLC or ACP and feel comfortable (7) and very comfortable (2) with their communication skills in this area of care are either very confident in their skills or lack insight to the complex issues of good and bad communication.

This (paper version 1) survey is a snapshot of EOLC / ACP knowledge base, education and practice within Wakefield Community Services, it will feed into the electronic survey, which has been available to all Mid Yorkshire employees during July, and the results will then be compiled and reported in August 2014.

Post Survey Note, Sept 2014:

Unfortunately only 9 people responded to the electronic survey, therefore this was not representative of the Mid Yorkshire Healthcare Trust workforce

Mid Yorks Data Collection for Clinically based Education and Training
Revised October 2014 (1st edition March 2014)

GP Data

1. Number of patients on the practice register 1/4/13 – 31/3/14
2. Number of deaths in the practice in the year 1/4/13 – 31/3/14
3. Number of GPs in the practice
4. Number of patients on an EoLC register – and do they have an ACP* (is this possible to collect)

Community

1. Number of deaths on the caseload of the teams targeted for training 1/4/13 – 31/3/14
2. Number of staff in those teams
3. Number of patients on the team caseload who are on an EoLC register – and do they have ACP?

Acute ACP and DNA CPR

1. Number of deaths on 2 'snapshot wards' in DDH and PGH targeted for training 1/4/14 – 31/3/15
2. Number of staff on the ward
3. % of staff who have received training
4. % of discharges in March 2014 on the 2 'snapshot wards' in DDH and PGH for who preferred priorities for care (PPC) and/or preferred place of death (PPD) were recorded in their discharge summary
5. Number of patients discharged in March 2014 on the 2 'snapshot wards' in DDH and PGH for whom DNACPR has been completed while in hospital
6. % of forms discussed with the patient and family for patients where the DNACPR form has been completed while in hospital *(figures from Resuscitation Team audit of DNACPR forms in existence on one day in 2013)*
7. % of forms signed by a clinician for patients for whom a DNACPR form has been completed while in hospital *(figures from Resuscitation Team audit of DNACPR forms in existence on one day in 2013)*
8. Number of patients discharged in March 2014 on the 2 'snapshot wards' in DDH and PGH for whom the discharge letter/summary mentions the existence of a DNA CPR form
9. Numbers of resuscitation attempts on 2 'snapshot wards' in DDH and PGH where we felt a DNACPR decision should have been made (*new data being collected by Resuscitation team)*

Notes and plan of action (March 2014):

- Useful comprehensive audits already undertaken by resuscitation team and we can work with them
- More meaningful to have note of attempted resuscitation when a DNACPR decision should have been made (point 9) rather than previous suggested points 9 & 10)
- EPaCCs being rolled out and it will be easier to collect data re existence ACP at the end of the project but this data should be available now for baseline
- 4, 5 ,8 will need Joy Waldock to look through Windip and may have to be a random selection and not ***all*** discharges in March
- Lynda Wright to get data GP 1, 2, 3
- Jo Schofield/community team to be asked to get data for Community 1, 2, 3
- Marian and Jan to get list of names of deaths and discharges on snapshot wards for March 2014 to give to Joy Waldock
- Zoe Heppenstall to help with data for Acute 6, 7, 9. NB: Is 7 helpful/needed?

June Toovey and Fiona Hicks agreed this new data on behalf of HWYH – email to Joy Waldock 2/4/14

	Total Number of patients in the GP practices 01/04/2013 – 31/03/2014	Total Number of deaths 01/04/2013 - 31/03/2014	Total number of GP's across the district 01/04/2013 – 31/03/2014	Total number of patients on an End of Life Care register 01/04/2013 – 31/03/2014	Total number of Patients on an EoLC register with ACP 01/04/2013-31/03/2014

GP DATA

1. Number of patient on the practice register 01/04/2013 to 31/03/2014
2. Number of deaths in the practice? 01/04/2013 to 31/03/2014
3. Number of GPs in the practice? 01/04/2013 to 31/03/2014
4. Number of patients on an EoLC register? 01/04/2013 to 31/03/2014
5. Number of pts on EoLC register with an ACP recorded? 01/04/2013 to 31/03/2014

Network 1	46,144	389	36	82	Nil
Network 2	57,940	431	43	125	2
Network 3	41,349	353	31	70	1
Network 4	56,155	553	46	179	10
Network 5	45,427	347	39	123	1
Network 6	63,369	421	48	174	4
Network 7	44,354	247	35	99	Nil
Total	**354,378**	**2,741**	**278**	**852**	**18**

COMMUNITY NURSING DATA

- Total number of patients on the caseloads? 01/04/2013 to 31/03/2014
- Total number of staff? 01/04/2013 to 31/03/2014
- Total number of deaths on the caseloads? 01/04/2013 to 31/03/2014
- Number of patients on the caseloads on and EOL register, of those how many had an ACP? 01/04/2013 to 31/03/2014

Community nursing teams Staff numbers 01/01/2014 – 31/03/2014	Number of Staff 01/04/2013 to 31/03/2014	Total number of patients on caseload 01/01/2014– 31/03/2014	Total number of deaths on caseload 01/01/2014 – 31/03/2014	Total number of patients on caseload who were on an EOLC register 01/01/2014 – 31/03/2014	Total number of patients on the caseload with an Advance Care Plan recorded 01/01/2014 – 31/03/2014
Team 1	44 WTE=31.56				
Team 2	35 26.35				
Team3	40 28.8				
Team 4	38 26.89				
Team 5	37 27.00				
Team 6	39 32.67				
Team 7 ICT	79 59.00				
Rehab	54 46.34				

Acute ACP and DNA CPR

10. Number of deaths on 2 ‘snapshot wards’ in DDH and PGH targeted for training 1/4/14 – 31/3/15
11. Number of staff on the ward (nursing)
12. % of staff who have received training
13. % of discharges in March 2014 on the 2 ‘snapshot wards’ in DDH and PGH for who preferred priorities for care (PPC) and/or preferred place of death (PPD) were recorded in their discharge summary
14. Number of patients discharged in March 2014 on the 2 ‘snapshot wards’ in DDH and PGH for whom DNACPR has been completed while in hospital

15. Number of patients discharged in March 2014 on the 2 'snapshot wards' in DDH and PGH for whom the discharge letter/summary mentions the existence of a DNA CPR form
16. % of forms discussed with the patient and family for patients where the DNACPR form has been completed while in hospital *(figures from Resuscitation Team audit of DNACPR forms in existence on one day in 2013)*
17. % of forms signed by a clinician for patients for whom a DNACPR form has been completed while in hospital *(figures from Resuscitation Team audit of DNACPR forms in existence on one day in 2013)*
18. Numbers of resuscitation attempts on 2 'snapshot wards' in DDH and PGH where we felt a DNACPR decision should have been made (*new data being collected by Resuscitation team)*

	Staff numbers % of these who have received training In ACP	Number of deaths March 2014	Number of discharges March 2014	Number of discharge letters and patient records checked on Windip	Number (%) of discharges with PPC or PPD documented in discharge summary	Number (%) of discharges with DNACPR completed in notes	Number (%) of discharges with DNACPR discussed with patient	Number (%) of discharges with DNACPR discussed with family/carers	Number (%) of letters where DNACPR form is mentioned in discharge letter
DDH 2 (elderly)	37 0%	12	38	7	0	3	1	0	0 *
DDH 8 (medical)	29 0%	12	73	8	0	1 **	1	1	0
PGH A2 neuro/stroke)	60 0%	17	115	8	0	0	n/a	n/a	n/a
PGH 41 (elderly)	29 0%	9	57	8	0	1	0 (dementia)	1	0
Total	**155**	**50**	**283**	**31**	**0**	**4 (13%)**	**2 (50%)**	**2 (50%)**	**0**
	0%								

* In this case it was suggested to the GP 'consider a DNACPR form' – it did not refer to one of the 3 patients where there actually was a completed DNACPR form in the notes – in all these 3 cases there was no mention of the form in the discharge letter.

** This form had been completed on a previous admission and taken into hospital by the patient/family.

Looking through the notes on e-WinDIP, there were several of the patients who probably should have had at least a DNACPR discussion and/or a form completed i.e. had multiple co-morbidities/frail/elderly/dementia and advance care planning would have been appropriate

Note:

I Had to look through all e-WinDIP sections in March 2014 and later dates (not always filed correctly) incl. nursing notes and A&E (for DNACPR forms) This was very time consuming so stopped after 31 sets of notes as all results were the same!

Some form of ACP may have been done with patient and family but not documented in discharge letter so not helpful to PHCT

DNACPR form could have been sent home with patient and no copy left in medical notes

Suggestions:

Alongside training in ACP can we look at some way of recording on discharge letters if ACP has been done i.e. can we influence the template?

MPET DNACPR Data

1. % of forms discussed with the patient and family for patients where the DNACPR form has been completed while in hospital *(figures from Resuscitation Team audit of DNACPR forms in existence on one day in 2013)*
2. % of forms signed by a clinician for patients for whom a DNACPR form has been completed while in hospital *(figures from Resuscitation Team audit of DNACPR forms in existence on one day in 2013)*
3. Numbers of resuscitation attempts on 2 'snapshot wards' in DDH and PGH where we felt a DNACPR decision should have been made (*new data being collected by Resuscitation team*

Data collected from the Do Not Attempt Resuscitation (DNACPR) Audit (October 2013)

Methodology:

A retrospective case note audit of in-patients on wards at the MYHT between August and October 2013.

A total of 37 wards were audited.

Total number of inpatients on wards at the time of the audit = 819

Total number of patient records available at the time of the audit = 796 (89%)

Total number of DNACPR forms identified = 148

Total number of DNACPR forms audited = 148

Number of patients with DNACPR	148	
Number of DNACPR forms discussed with family	70	47.3%
Number of DNACPR forms discussed with the patient	32	21.6%
Number of DNACPR forms signed by a clinician	148	100%
Number of patients who were admitted with a DNACPR form	29	19.6%
Number of resuscitation attempts where we felt a DNACPR decision should have been made	Awaiting Data **	

** Awaiting data from resuscitation team Dec2014

Train the Trainer Pre Questionnaire and Comments

1. WHAT DOES ADVANCE CARE PLANNING MEAN TO YOU?

Listening to what matters to the patient.	3
Helping the patient to think about their wishes when they become more poorly	9
Planning for their future	5
Making it formal	7
Pt able to choose where & how they wish to die	7
Reduce their anxiety	1
Planning services and equipment for end of life pts	1

** This highlights that staff are aware of ACP and what it means, the staff who attended this training were all senior nurses.

2. HOW CONFIDENT DO YOU FEEL IN STARTING A CONVERSATION WITH PEOPLE ABOUT END OF LIFE ISSUES ON A SCALE OF 1 TO 10 1=VERY 10=NOT AT ALL

1	2	3	4	5	6	7	8	9	10
0	0	7	4	3	1	2	4	1	1

** Predominantly people felt fairly confident with a few exceptions.

3. NAME 3 ISSUES THAT MAY HINDER YOU HAVING THESE CONVERSATIONS?

Time	2
Fear	3
Environment	3
Pt anxiety	1
Engaging GP	1
Relatives	12
Pts understanding	2
Non appropriate	1
Patients don't want it!	6
Unexpected questions	1
Relationship with patient	1
Prognosis	3
Lack of experience	3
Lack of confidence	3
Pt too poorly	2
Personal issues	3
What to say	1
How to start conversation	1

** This suggests that the main hindrance for staff in discussing ACP is the relatives and the patients not wanting to discuss.

IN AN AVERAGE WORKING WEEK, HOW OFTEN DO YOU TALK TO PEOPLE ABOUT END OF LIFE ISSUES?

Daily	4
Not often	2
Sometimes	4
2 patients per week	7
Lots	3
1 patient per week	2
When patient dying in their PPC	1

** 60% talked to patients at least twice a week and some daily

4. CAN YOU RECALL A POSITIVE EXPERIENCE IN END OF LIFE CARE?

Personal experience	2
Patient died peacefully with family present	4
Lots	3
Listening	1
FastTrack discharge to PPC	5
When patient had everything planned	2
Family grateful wishes were met	1
Patient died in their PPC	1
None	2

5. WHAT TYPE OF PATIENT WOULD YOU CONSIDER HAVING THESE CONVERSATIONS WITH?

All	7
When patient asks	1
Palliative patients7	7
EOL dementia patients	3
Long term condition patients	3
Elderly patient	1
Patient with a poor prognosis	1

End of Life Care Education Facilitators' Progress Report - Feb 2015
Jan Walker and Marian Oakhill
Advance Care Planning

Objective	**Action/Recommendations**	**Outcome/Measures**	**R**-red **A**-amber **G**-green	**Update/comments**
To promote the role. Build relationships Network with relevant community and hospital services	Continue promoting project at every opportunity via media internal and external to organisation. Promote and present project at GP target events and GSF meetings. Engage and present project at various meetings across community and hospital services.	Had productive engagement with local and regional service leads. Service leads aware of project and support role out of training and ACP in their departments and practice areas. ACP project promoted in local news bulletins.		Ongoing Delivered workshop at national conference.
To deliver training on target wards across Trust	• Target wards identified • Attend senior sisters meetings PGH & DDH • Liaise with hospital matrons • Other areas identified for training	• Matrons aware of wards to be targeted • Re arrange dates for sisters meeting • Met with ward sisters on all target wards, keen to commence training • Dates arranged to commence training on all target wards • Joint training with CNS in Palliative Care		Trust in response to increased demand is at REAP 5 status Time constraints and difficulties releasing staff, continue to be an issue. Specialist hospital teams to be contacted after restrictions (REAP 5) lifted. Feedback to target wards. Manned Information stands.

To deliver training to community services including GP's and their practice staff, community nurses and AHP	• Contact Practice Managers • Engage with Practice Educators • Present at network events	• Dates arranged for training • Increased % of community services received training		GP,s contacted and Community services to arrange future dates, follow up via CCG
Provide training to affiliated agencies and service providers	• Identify appropriate groups • Offer appropriate audience relevant material • Deliver appropriate training	• Improve interagency communication • Improve patient / client experience		Hospice joint training Regional event Bereavement forum Marie Curie MND event
To improve skills and knowledge of ACP for clinical teams across the community and hospitals of Wakefield District.	• Devise Pre and post education questionnaires • Establish current status of ACP (Data) • Monitor impact on patient outcomes • Target wards identified for data collection	Positive impact on patient experience. Competent and confident workforce when delivering ACP.		Ongoing positive feedback from training, evaluations Specialist team training arranged
Project progress Report	• Write a report, ongoing update monthly • Feedback to steering group, successes/ barriers	Feedback at regular Steering Group Meetings		Ongoing Summary report of hospital training submitted to Dawn Parkes, Associate Director of Nursing.

Deliver education and training on ACP to clinical teams across hospital and community	• ACP • PPC (current documentation) • DNACPR • Communication • Offer short and longer sessions • E-Learning • Be flexible • Use of scenarios • Audience appropriate • Questionnaires/feedback • Certificates of attendance • Role play • Dying matters • GSF meetings • Grand round • EPaCCS	Clinical teams will be more confident & competent in discussing ACP with their pts and families Increased number of pts on the end of life register Enhanced patient and carer experience Ultimately increased number of pts dying in their POC & their wishes being met Training for GPs & community nurses commenced, evaluating well		commenced May 2014 Identified areas that have had no EPACCS training i.e. GP practices, promoted and arranged contact with Kath Lambert Consultant in Palliative Medicine. Evaluation of half and full days, evaluating well was increasing in popularity. Sessions cancelled due to REAP 5. Ongoing

Advance Care Planning

Evaluation of Training given June & July 2014

Purpose of training:

The purpose is to improve patient care / experience by enhancing staff skills, knowledge, confidence and competence around advance care planning.

Authors:

Jan Walker & Marian Oakhill

Background:

Our remit is to provide practice based training in Advance Care Planning for clinical teams within Mid Yorkshire Hospitals, Wakefield District Community and Wakefield GP Practices. This project has been funded by Health Education Yorkshire and the Humber, who identified this as a key area of need. This report was undertaken following the first 2 months of training to ensure the training delivered is effective and relevant to the audience and pitched at the right level.

Method:

An evaluation form was designed and supported by two End of Life Care (EOLC) Education Facilitators, a Consultant in Palliative Medicine and a GP EOLC Lead.

It was given to all staff immediately following their training to complete. The same form was used for all training delivered whatever the length.

The results were evaluated and reported by the EOLC Education Facilitators.

Evaluation Results:

Community clinical teams were offered training in their place of work; the sessions were delivered for 1 hour, 1 ½ hours or 2 hours.

Staff Groups Trained:

47% of staff trained were qualified nurses

33% were GPs

20% other

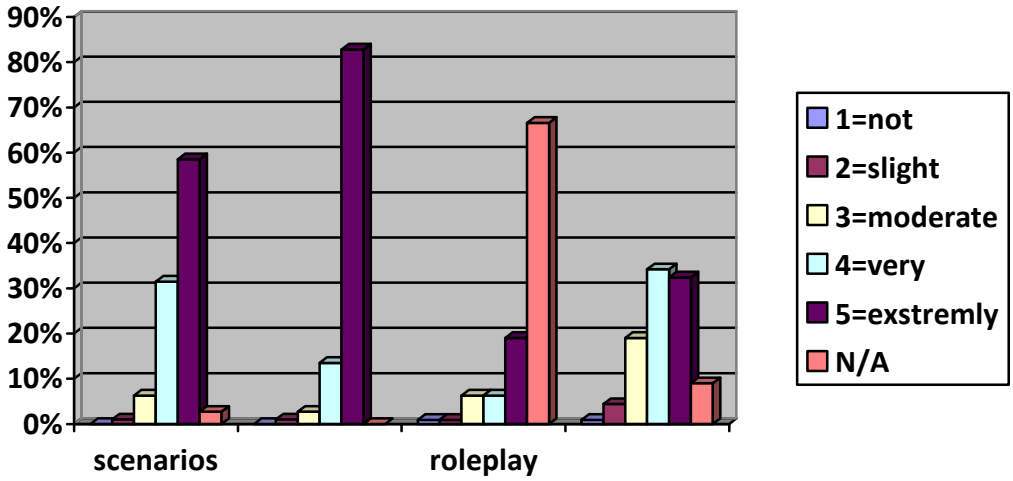
1. <u>Learning Outcomes</u>

Please state whether or not you feel the learning outcomes for this workshop were achieved**:**

99% of staff trained felt the learning outcomes identified were achieved

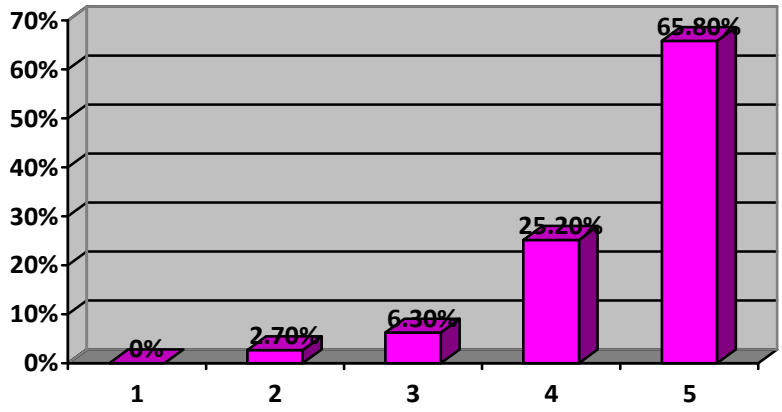
2. Variety of Training Methods Employed

Please rate how effective you found the variety of training methods (applicable) employed whereby 1 is not effective, 3 is moderately effective and 5 is extremely useful.



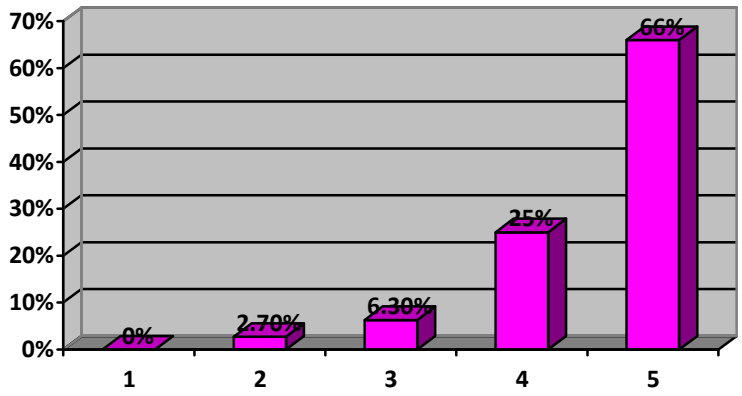
3. Overall Content of the Course

Please rate how useful you found the training, whereby 1 is not useful, 3 is moderately useful and 5 is extremely useful.



4. Value of course

Please rate how useful you found the course with regard to working within your current role whereby 1 is not useful, 3 is moderately useful and 5 is extremely useful.



Findings:

- 133 staff completed the training, 22(17%) did not complete an evaluation form.
- The largest staff group trained were qualified nurses.
- The learning outcomes were achieved apart from 1 out of 111 who felt they were not achieved
- Out of the variety of training methods employed discussion and scenario work evaluated as the most effective.
- 71(65%) staff found the overall course content extremely useful. 73 staff found the training extremely valuable in regards to their current role.

Respondents Comments: (some examples)

- Informative, relaxed group work
- Relevant to role, created a lot of discussion
- Increased awareness of this being everyone's job
- Enjoyed presentation and taking part in discussion
- Always interesting to hear how others deal with different situations
- Very good set up with mix if training methods, good use of scenario work
- Very thought provoking and relevant to current situation, but not enough time
- Would have liked more life examples, needed pitching at a slightly higher level

Discussion:

The training methods used identified the need for training in advance care planning and the importance and relevance of bringing people together in groups in order to share experience.

A variety of training methods were used, these being power point, discussion, scenarios and role play (time allowing). All methods evaluated well although discussion and scenario work evaluated as being the most effective method.

Training has identified that staff were able to recognise the importance and relevance of advance care planning training to their practice.

Evaluation has supported the training in that it is delivered effectively and relevant to the audience, and pitched at the right level.

We can conclude that training multidisciplinary groups generated ‘richer ‘discussions and made the training more interesting and interactive.

This report is a snapshot of the evaluation of our ACP education and training within Wakefield Community Services, which has been available to all Mid Yorkshire employees during May and June, and the results from this report and others to follow will be compiled and reported in our final report in August 2015.

Evaluation Comments from ACP training

"small groups encouraged lots of open discussion and shared experience"

"a really great session"

"great food for thought"

"hope you manage to get through a lot of Health Professionals"

"excellent course, good chance to learn and discuss with others"

"I would definitely recommend this to my work colleagues"

"excellent course also helped using personal experience and being able to talk openly, very good"

"found this extremely useful to take back to my work area"

"very interesting study session, a good mixture of learning"

"gained extra confidence from the day"

"very informative course delivered in a relaxed manner that allows for explanations and discussion"

"I found this a valuable session, I now feel much more comfortable speaking to patients and family/carers"

"It has been beneficial to add to my repertoire of stock openers etc. and will be good to take back to colleagues"

"very thought provoking made me think about things I hadn't thought about before, will be very useful for my practice"

"the course content was very useful to my role and will in future make me think differently of how to approach difficult conversations"

"board game brilliant, lovely relaxed and informative"

"a really valuable opportunity to explore and discuss care planning and associated issues, really well facilitated"

Comments from various training session (3 hours – full day) and from all disciplines of health professionals.

Community End of Life Care Register Data

	Total death on EOL register	ACP Recorded	ACP % recorded	Preferred place of death recorded	Preferred place of death achieved	DNACPR Decision recorded	Anticipatory medication available	OOHs handover form completed
2013/14 pre training	733	18	2.5%	366 (49.9%)	No data Available? **	462 (63%)	No data available	27 (3.7%)
2014/15								
Q1	110	65	59.1%	90 (81.8%)	?	91 (82.7%)	17 (15.5%)	30 (27.3%)
Q2	190	134	70.5% ☺	152 (80%)	?	158 (83.7%)	40 (21%)	47 (24.7%)
Q3	208	127	61.1%	180 (86.5%)	?	179 (86.1%)	58 (27.9%)	54 (26%)
Q4	192	102	53.1%	151 (78.6%)	?	169 (88%)	44 (22.9%)	48 (25%)

☺ Most GP and Community training delivered within this quarter. These figures would suggest that ACP discussions with patients increased during this time due to training??

** Check is this data is available?

APPENDIX 8

Hospital Training on Advance Care Planning (ACP) and Communication Skills related to ACP

By: Jan Walker & Marian Oakhill

November 2014

Initially we contacted senior management to alert them to the project and ensure they were informed with regard to the Project Initiation Plan.

We had a meeting with Dawn Parkes, in April 2014 who advised us to meet with the matrons and attend a Sisters meeting. We also e-mailed Sally Napper on her recommendation and had a positive response.

Our first stumbling block was our lack of understanding of the structures below senior management of the trust and which matrons manage which areas. We were unable to meet with any of the matrons we had contact details for, there would appear to be frequent movement within this staff group, though we did attend one meeting as arranged and we were the only attendees. We did meet one matron on one of the wards who did give us some information which was very useful.

We then took the decision to approach the ward sisters/charge nurses directly, and made appointments to explain the project, which turned out to be successful, we were warmly welcomed by all clinical areas and invited to either ward meetings and /or daily sessions where we would gather staff who could be released for 30-45 minutes.

The training was undertaken from July - November 2014 after negotiating times and dates with each senior ward sister/charge nurse.

During this period it has to be recognised that there were shortages of staff in all of the clinical areas, with frequent movement of staff between wards and departments and new staff. Due to the 12 hour shifts there was also no overlap of staff during the day. Therefore though all the staff we met were keen to receive training, at all levels, the opportunity to release staff, though pre-planned, was very limited. All wards identified the best time to release staff was between 1:30 – 2:30, therefore it limited how many wards we could attend at one time.

All the nursing staff were keen to learn and enthusiastic about ACP and could appreciate how beneficial this is for their patients. Of the 71 nurses who had training 2 had heard of ACP before, none had seen the PPC document and we ensured each ward had batches of these documents delivered to their ward while we were attending. We also offered ACP materials to help them develop a display board.

Ward	Occasions Attended - Ward	Occasions When Staff Available	Numbers Trained
41	20	1	4
42	4	0	0
43	15	5	18
44	3	1	4
A2	16	5	30
DDH 2	7	2	9
DDH 8	8	3	6
Total	**73**	**17**	**71**

We attended the wards on 73 occasions and the time taken was between 10 minutes to 90 minutes depending on how long we had to wait to either establish if anyone could be released, or to deliver training.

The training is delivered by band 7 nurses (1.6 WTE) with extensive clinical experience therefore an expensive resource. These nurses are based at the Wakefield Hospice.

We have a training programme which we delivered across site. These sessions are open to all clinical staff and are evaluating very well, with evidence that it is changing practice.

It is evident to us as trainers (confirmed by evaluation and follow up) that this form of training is more efficient, effective and staff have time to reflect on practice and consider how to apply the principles of ACP to their practice areas. Releasing staff away from clinical areas (community and hospital) and mixing with other colleagues enables them to share experience, understand the broader perspective and appreciate the whole system approach to patient care, they learn from each other.

Hospital staff attended:

	Consultants	Doctors	Senior Nurse	Staff Nurse
Full Day			9	7
Half Day			3	4
Hour	10	15	8	3
Total	**10**	**15**	**20**	**14**

Therefore total hospital staff trained = 130

Evidence suggests that if there is a whole system approach to ACP then the patients who have a palliative condition will have an improved experience and care:

- Reduced inappropriate investigations and treatments
- Reduced inappropriate hospital admissions
- Improve anticipatory prescribing for symptom control
- Increase the number of patients with an ACP
- Increase the % of patients who die in their preferred place of care/death
- Reduce bereavement associated problems

This project started in March 2014 (finishes in September 2015) and we have been training community staff also, using both approaches. It is apparent to the trainers that it has been more successful to deliver training to community staff in small and larger groups.

Total Community Staff (GPs–HCSW) = 364

Recommendations:

- That all staff working with patients who have life limiting conditions have ACP training.
- That all staff working with patients who have life limiting conditions have training in communication skills and is a core competency.
- That ACP training is essential to role.
- Staff are released from their clinical areas to receive training where they have the opportunity to share experience with staff from other clinical areas.
- ACP documentation (i.e. Preferred Priorities for Care) available throughout the hospital.
- That any ACP discussions/decisions should be clearly documented in patient's notes and the discharge letters.
- Any patient who has given permission to be on the Electronic Palliative Care Co-ordination System (EPaCCS) is identified on admission, utilising the icon on the SystmOne (S1) boards in clinical areas.