Final Report
Evaluation of the Advance/Anticipatory Care Planning (ACP) Facilitators' Training Programme

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For

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1 Introduction

In February 2010, NHS Education Scotland (NES) appointed Inspire Research Ltd and Fortuno Consulting to undertake research to evaluate the Advance/Anticipatory Care Planning (ACP) Facilitators' Training Programme. This report presents an overview of the findings of the three phases of the study and assesses the degree to which the Facilitator Training Programme and Resource Pack have prepared the cohort of facilitators with the knowledge, skills and tools to deliver training initiatives in ACP to address local and regional needs.

2 Background

Advance or Anticipatory care planning (ACP) *"as a philosophy, promotes discussion in which individuals, their care providers and often those close to them, make decisions with respect to their future health or personal and practical aspects of care"* [1]. This is likely to take place in anticipation of deterioration in the individual's condition with potential loss of capacity to make or communicate decisions or wishes. ACP is an important part of good quality palliative and end of life care. The ACP process promotes patient-centred care and improves quality of living and dying irrespective of care setting [2]. Education and training in ACP is therefore essential for all staff involved in the delivery of palliative and end of life care.

Broad policy drivers for the development of ACP Facilitators' Training could be seen as starting from policy priorities articulated in Delivering for Health, Building a Health Service Fit for the Future, and Better Health Better Care [3,4,5]. *Better Health Better Care* made clear the Scottish Government's intention to introduce a single, comprehensive approach to the provision of palliative care across Scotland.

Audit Scotland published its *Review of Palliative Care Services in Scotland* [6] the year after Better Health Better Care. At that time, specialist palliative care services were found to be primarily cancer-focused, with the majority of palliative and end of life care being provided by generalist staff in hospitals, care homes or patients' own homes. It identified that "*Training and education need to be developed for health and social care providers to improve access to high-quality general palliative care*". The report made two recommendations on education and training:

- NES should work with NHS boards, Community Health Partnerships (CHPs) and their council partners to ensure there is appropriate training in place for general staff to identify patients with palliative care needs and improve the quality of care provided.
- NHS boards, CHPs and council partners should work together to ensure all staff providing general palliative care receive relevant training to identify and care for patients with palliative care needs. This includes staff working in primary and community care, hospitals and care homes.

[1] Scottish Government (2011) *Living and Dying Well: Building on Progress*. Working definition retrieved from: http://www.scotland.gov.uk/Publications/2011/01/27090834/6
[2] http://www.strathcarronhospice.org/nes.html
[3] Scottish Executive (2005) *Delivering for Health*, Edinburgh.
[4] Scottish Executive (2005) *Building a Health Service Fit for the Future*, Edinburgh
[5] Scottish Government (2007) *Better Health, Better Care*, Edinburgh.
[6] Audit Scotland (2008) *Review of palliative care services in Scotland.* Edinburgh.

Subsequently, a national action plan was published under the title *Living and Dying Well* [7]. This came alongside the appointment of a National Clinical Lead for Palliative Care and each NHS Board identifying an Executive Lead to take this forward. (It should also be noted that since the start of this evaluation study, *Living and Dying Well: Building on Progress* [8] has been published, this documents progress towards the aims of Living and Dying Well, and outlines actions required of NHS Boards working with stakeholders.)

In response to the above agenda, NES tendered for and commissioned the development and delivery of Advance/Anticipatory Care Planning Facilitator Training. The training aimed to prepare a cohort of ACP facilitators to address local and regional needs by delivering ACP training initiatives based on NHS Board priorities and plans. There was also the requirement to produce a resource pack for facilitators to support local ACP training across Scotland. This was delivered in the spring of 2010.

3 Evaluation aim and objectives

The aim of this study was to undertake an evaluation of the ACP Facilitators' Training Programme in terms of its relevance, appropriateness, and impact. The evaluation had five objectives:

- Objective 1: Assess the relevance of the ACP Facilitator training to participants' own practice
- Objective 2: Investigate participants' perceptions of the learning materials and facilitators resource
- Objective 3: Explore strategies adopted to deliver training within participants' NHS boards
- Objective 4: Appraise the approach adopted in relation to supporting local delivery of education and training in ACP and organisational sustainability.
- Objective 5: Investigate experiences of participants in then delivering ACP education and training (including successes and challenges)

4 Approach

The methods used to address the evaluation objectives are summarised in Table A. Essentially, the study was arranged in three phases. Phase 1 involved an online survey of delegates who attended the ACP Facilitators' Training, on completion of the face-to-face training sessions in March/April 2010. Phase 2 took place in October 2010, six months after the training, and delegates were again asked to complete a revised online survey. A selection of those who had delivered ACP training was also invited to take part in telephone interviews. In Phase 3, in April/May 2011 i.e. twelve months after the training was completed, there was a final online survey, and a wider group of delegates were invited to take part in telephone interviews, and some spot interviews were undertaken.

[7] Scottish Government (2008) *Living and Dying Well: A National Action Plan for Palliative and End of Life Care in Scotland*. Edinburgh.
[8] Scottish Government (2011) *Living and Dying Well: Building on Progress*. Retrieved from: http://www.scotland.gov.uk/Publications/2011/01/27090834/0

Table A – Summary of approaches applied to meet objectives

Objective	Method
1. Assess the relevance of the training to participants own practice	▪ Questionnaires post-training, at six months and one year after training ▪ Participant interviews at six months and one year after training
2. Investigate participants' perceptions of the learning materials	▪ Questionnaires post-training, at six months and one year after training ▪ Participant interviews at six months and one year after training
3. Explore strategies adopted to deliver training within the participants' NHS board area	▪ Participant interviews at six months and one year after training ▪ Review of strategy documents highlighted by participants
4. Appraisal of the approach adopted in relation to supporting local delivery of education and training in ACP and organisational sustainability.	▪ Questionnaires at six months and at one year after training ▪ Participant interviews at six months and one year after training
5. Investigate experiences of participants in then delivering ACP education and training (successes and challenges)	▪ Questionnaires at six months and at one year after training ▪ Participant interviews at six months and one year after training

5 Findings

Findings from Phases 1 & 2 have been reported to NES previously. This final report pulls together the earlier findings along with those from Phase 3. The following section starts with an overview of the profile of ACP Facilitators who responded to the different surveys. This is followed by the findings from the post-training survey, and six-month and one-year follow-up surveys and interviews, reported under the five key evaluation objectives.

5.1 Demographic overview of respondents to the online surveys

A total of 120 individuals were listed as delegates on the ACP Facilitators' Training Programme. The pattern of responses, and non-responses, to the evaluation surveys are shown in Table B. From the original cohort, there were 75 responses to the post-training questionnaire (Phase 1), 40 responses were received to the six-month follow-up questionnaire (Phase 2), and there were 41 responses to the final follow-up survey that was administered after a year (Phase 3).

Table B – Breakdown of responses to surveys at different phases of the study

Response to different phases	No. of delegates
No response to any phase	24
Phase 1 (Post training) only	26
Phase 2 (six month follow-up) only	5
Phase 3 (twelve month follow-up) only	2
Phases 1& 2	10
Phases 2 & 3	2
Phases 1 & 3	14
All Phases	23
Indicated that did not attend training	1
Opted out at start (Phase 1)	1
No email available	12
Total	120

There was, however, an inconsistent pattern of response to the surveys. For example, 15 delegates responded to Phase 2 but not Phase 3, and 16 responded to Phase 3 but not Phase 2, meaning that just 25 responded to both. This should be remembered when comparing findings across the different phases, as they are drawn from different groups.

The post-training questionnaire (Phase 1) included more detailed demographic questions than in the later phases. Responses showed that:

- 90.5% (n=67) of respondents were aged between 36 years and 55 years.
- 93% (n=68) of respondents were female (one person skipped this question).
- 70% (n=47) of respondents held a degree or postgraduate qualification, although a further nine respondents listed an MSc or PhD as their highest qualification.

In terms of previous experience, training was the main aspect of the role of 28% (n=20) of Phase 1 respondents. A further 54 % (n=39) of respondents reported that they delivered training regularly but it was not the main aspect of their role, and 19% (n=14) said that it was only an occasional aspect of their role. About a third of respondents (n=25) had more than ten years experience in their current role. Just over half (n=37) had between three and 10 years experience, the remaining 16% (n=12) had less than three years experience in their current role.

As shown in Table C, almost half the respondents had undertaken formal training on facilitation lasting for at least one day. While just over a tenth of respondents had had no previous training in facilitation.

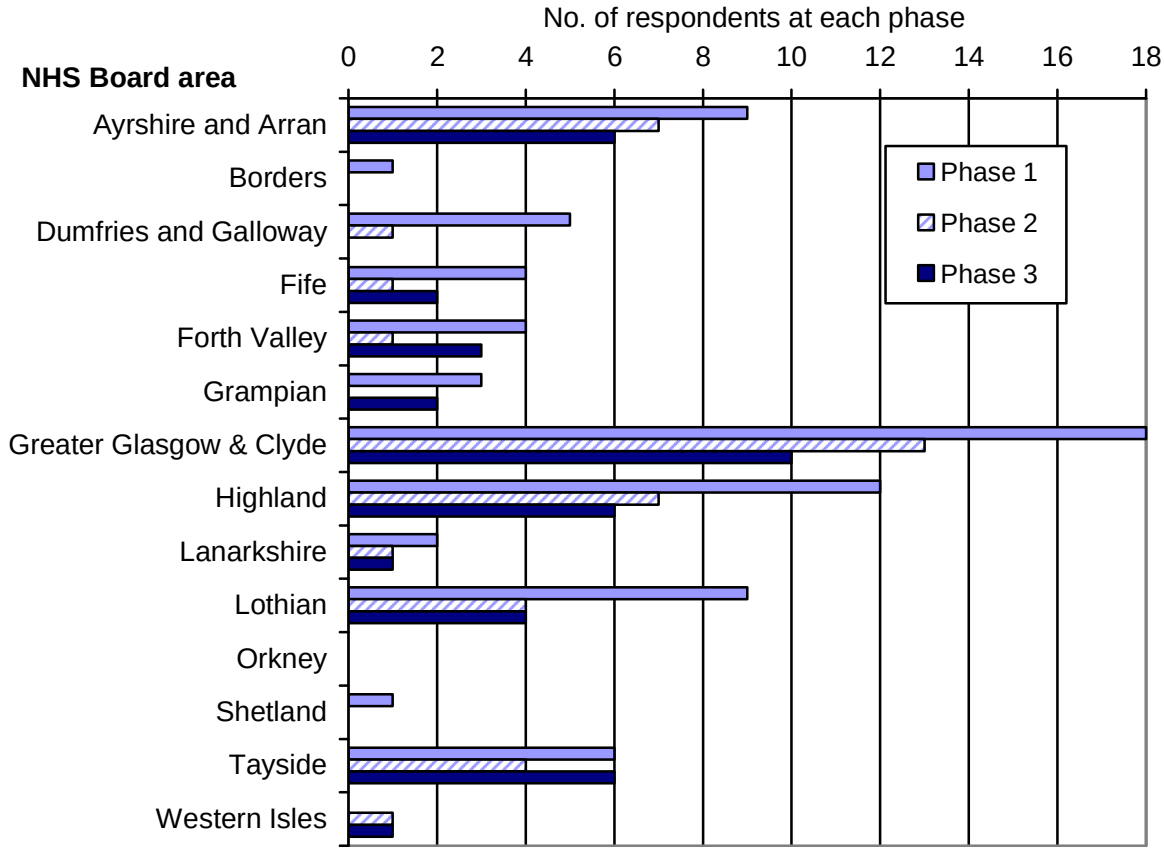
Table C – Responses from Phase 1 to the question 'How much training on facilitation have you had previously?'

Answer Options	Response Percent	No. of respondents
None	11.6%	8
Informal training (e.g. from discussions with colleagues)	17.4%	12
Have heard presentation(s) about facilitation	13.0%	9
Formal training lasting less than one day	10.1%	7
Formal training lasting a day or longer	47.8%	33

This suggests the whole cohort were mainly individuals with at least some formal responsibility for training and with previous experience of facilitation. A relatively small proportion of the group had lower levels of experience, and this is noted later in relation to some of the survey responses.

Figure 1 shows the distribution of respondents across NHS Board areas for all three phases of the study. Greater Glasgow and Clyde had the largest response at all phases, although this is the largest board so this is perhaps not surprising. There was also a high response from Highland and Ayrshire and Arran, and a fairly consistent response from Lothian and Tayside.

Figure 1 – Responses from all phases to the question 'Within which health board area is your organisation located?'



The distribution of respondents according to professional group remained roughly the same across all phases of the study; most respondents were nurses (72%-82%) followed by educators (12%-15%), and a smaller group of clinicians (7%-10%). In Phases 2 & 3 respondents were also asked for their professional role, see Table D.

Table D – Responses from Phases 2&3 to the question 'What is your professional role?'

Professional role	No. of respondents at Phase 2	No. of respondents at Phase 3
Clinical Nurse Specialist	9	7
Practice Educator	6	2
Practice Development Facilitator	5	3
Learning & Development Facilitator	4	1
GP	3	1
Palliative Care Nurse	3	4
District Nurse	2	6
Macmillan Nurse Facilitator	0	3
Palliative Care Lead	1	2
Deputy/ Charge Nurse	1	2
Clinical Improvement Practitioner, Hospice Education Facilitator, Management Team Support Nurse, (Respiratory) Specialist Nurse	1 of each	1 of each
Other (no detail given), Practice Education Facilitator	1 of each	0
Cancer and Palliative Care Facilitator, Care Home Liaison Nurse, Lecturer, Palliative Care Educator, Specialist Physiotherapist,	0	1 of each

As noted above, while there was a core of 25 delegates who responded to Phases 2 & 3, the two cohorts were not entirely the same. Table D demonstrates that there were differences in professional roles between the groups.

Those who responded to the questionnaires worked in a wide range of organisations as shown in Table E. The largest numbers worked in an Acute Hospital, a Community Health Partnership, or a Hospice.

Table E – Overview of responses regarding 'What type of organisation do you work in?'

Type of Organisation	Phase 1	Phase 2	Phase 3
Acute and community	2	3	5
Acute Hospital	**18**	**9**	**6**
Community Health Partnership	2	**9**	**8**
Community Hospital	5	0	2
Community Nursing	3	3	7
Day Hospice	0	1	0
GP Practice	5	3	1
Hospice	**10**	**6**	**9**
Mental Health Hospital	2	1	1
Other Community Service *	**14**	0	0
Other Primary Care	3	3	0
Rehabilitation centre	0	1	0
Voluntary organisation/Charity	1	1	0
Ambulance Service, Care Home, Health Centre, or other regional service	8	0	0

* Additional response options were added after Phase 1, which partially explains the relatively high response to 'Other Community Service' at Phase 1.

5.2 Objective 1: Assess the relevance of the ACP Facilitators' Training to participants' own practice

5.2.1 The training met the majority of respondents' expectations

The single day face-to-face format of the training suited all bar one of the Phase 1 respondents, although a further nine percent indicated that it only slightly suited their needs.

The majority (86 %, n=58) of those who responded to the first survey also reported that the training covered information that was new to them. Most reported that the training met or exceeded their expectations, as shown in Figures 2 and 3. These and other results from Phase 1 (such as shown in Figure 7) indicate most respondents viewed the training positively. A significant minority (more than a third of Phase 1 respondents) did not, however, have their expectations met in relation to gaining knowledge of ACP, practical implementation of ACP, nor board specific training. (Although most did not expect the latter to be covered in any depth.) Given that the first two areas were those most expected to be covered, the Phase 1 results suggest additional support or resources in these areas would be valuable. Indeed, since the conclusion of data collection for this study, additional online resources have been commissioned by and developed on behalf of NES [9].

[9] This includes the Advance & Anticipatory Care Planning Toolkit http://www.palliativecareinpractice.nes.scot.nhs.uk/advance-anticipatory-care-planning-toolkit/ and the Palliative and End of Life Care Work-Based Learning Resource http://www.palliativecareinpractice.nes.scot.nhs.uk/palliative-end-of-life-care-work-based-learning-resource/

Figure 2 – Responses from Phase 1 to the question 'What particular areas did you expect to cover within the training?'

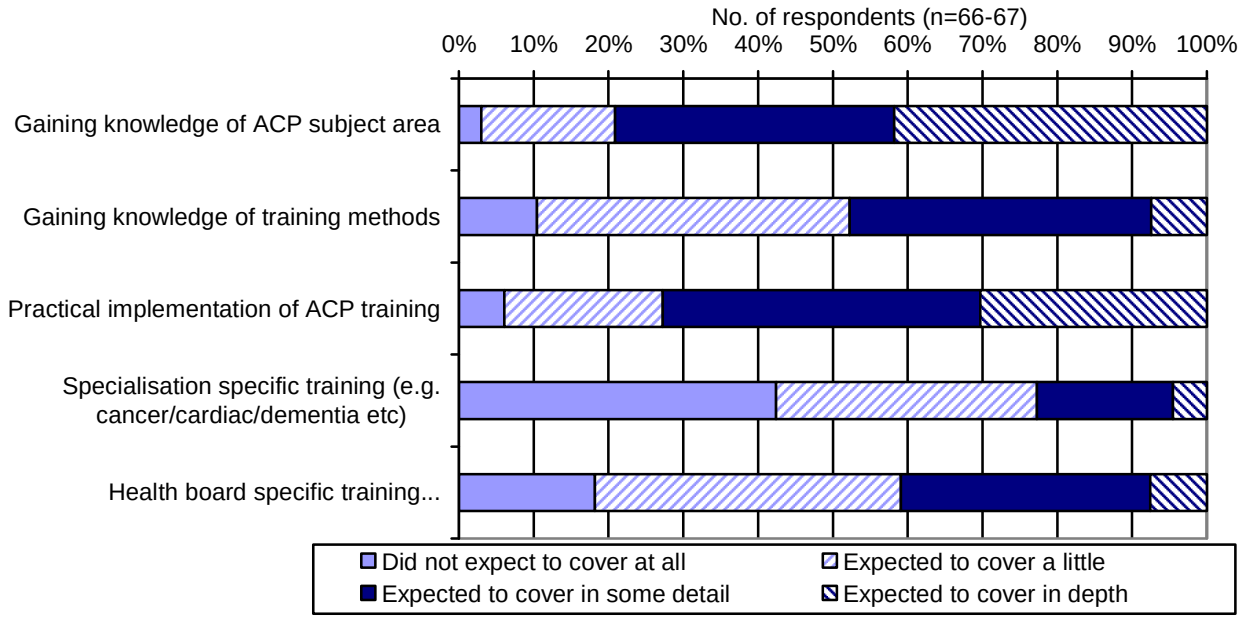
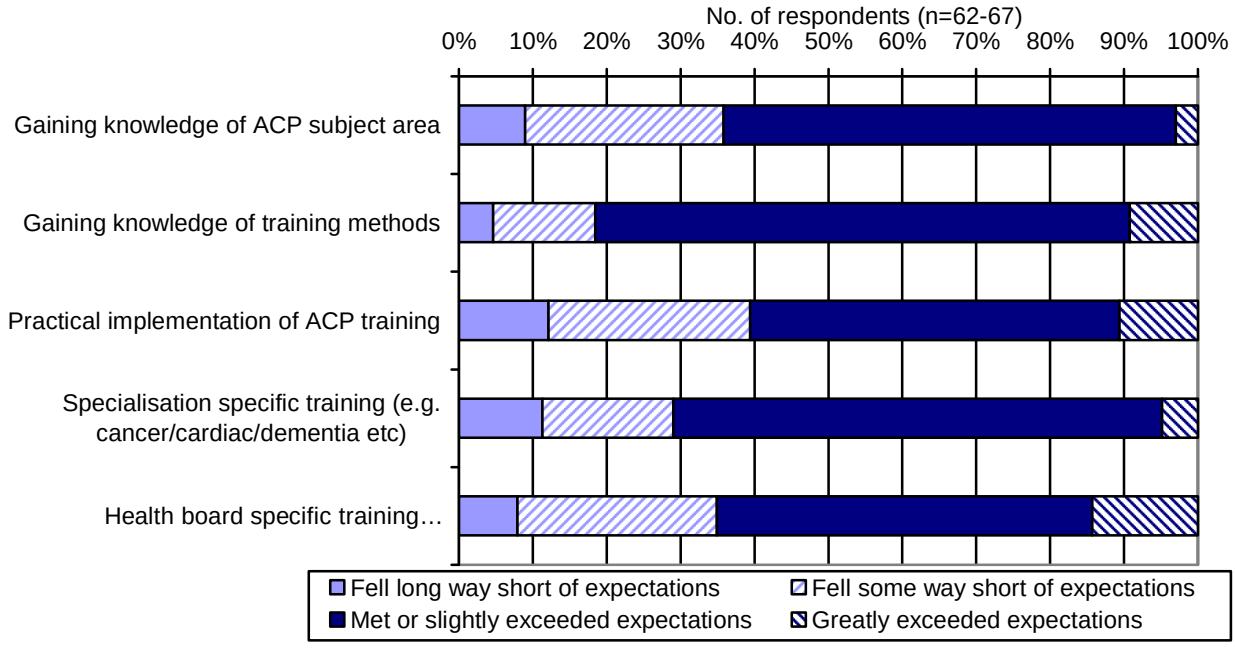


Figure 3 – Responses from Phase 1 to the question 'Were your expectations met?'



More than four out of ten Phase 1 respondents suggested other areas that they would have liked to be included in the training. The most requested area related to implementation of the ACP process and associated documentation (10 respondents mentioned this). For example,

> *"I would have liked clearer guidelines around the use and application of ACP across this health board, how managers will facilitate the rolling out of training to everyone who needs it particularly medical staff."*

and

> *"I understood that I would see the paperwork that would be used and familiarise myself with it. More information on the concept of ACP and implementing it."*

This points to the need for guidance in this area, although at the time of the ACP Facilitators' Training it was relatively early in terms of implementing Living and Dying Well and few NHS boards would have had ACP systems and documentation in place. Other content areas requested by respondents included more on long-term conditions (2), communication skills and initiating ACP discussions (2), and legal aspects (1). Some of these have been addressed in the new NES funded ACP Toolkit and Work-Based Learning Resource mentioned above.

There was also a request to:

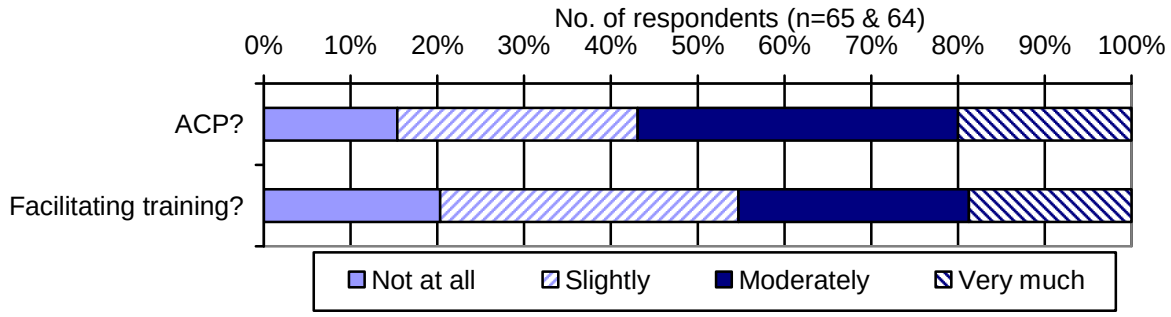
> *"have the training pack divided into plans addressing time limitations. For instance most felt unable to commit one full day to training and may only have 15 - 20 minutes, leaving it to the facilitator to decide what would be important or not. This is not consistent with the delivery of education nationally as many could leave out the most significant elements of ACP implementation."*

From the interviews, there was a slightly mixed response to the training day itself. Some interviewees had found it useful to run through the pack as if it were a 'training day', noting, "*it was good that the course content followed the structure of the pack that was issued afterwards*" (3P024) [10]. One interviewee felt this was too time consuming, and was concerned overall that "*it is totally unrealistic to think we'll have a day to train people*" (2P089). Another interviewee felt the "*most I got out of it was networking*", although this person went on to say, "*I have used the powerpoints, and haven't changed things*" (2P025). While interviewees were not explicitly asked about the networking value of the ACP Facilitator's training day, it seems likely this is an important additional benefit of these kinds of regional multi-professional meetings. (Indeed, another interviewee reflecting on subsequent local training delivery also highlighted this.) Certainly, there were a number of comments about the value of "*hearing about other people's experiences*" (3P024). Others felt "*the training was all I needed*" (3P008). Targeting appropriate delegates, offering regional sessions, and ensuring the intent of any face-to-face sessions is clearly conveyed are all key aspects of this kind of national training initiative.

5.2.2 The training increased most respondents' knowledge and confidence in facilitating ACP training

The training day was reported as having increased most participants' knowledge of both ACP and of how to facilitate training, as shown in Figure 4.

Figure 4 – Responses from Phase 1 to the question 'Do you feel undertaking this training has increased your knowledge of …'



[10] Quotes from interviews undertaken at six months after training, i.e. Phase 2, are indicated by a '2' in front of the interviewee's unique identifier, which is made up of 'P' followed by a unique number. A '3' in front indicates quotes from interviews undertaken at twelve months after training, i.e. Phase 3.

Almost two thirds of respondents (n=41) who completed the first survey also felt more confident about facilitating ACP training in their own area. (A further 28% (n=18) did not feel their confidence level had changed and eight percent (n=5) felt less confident.) Furthermore, after attending the Facilitators' Training almost three quarters of respondents (n=45) felt moderately or very confident/comfortable about running an ACP training event.

A relatively small group (10%, n=6) of respondents did not feel confident about running an ACP training event, and 18% (n=11) only felt slightly confident. This may relate more to the extent of their prior experience, as indicated in Section 5.1, rather than the training itself. Nonetheless, it may be valuable to offer additional support in future. For example, one interviewee found "*the teaching strategies parts left me feeling slightly out of my depth, and I probably wouldn't take it forward because I felt that*" (3P011). This person was in quite a close-knit setting, and did not feel empowered to take the training forward noting that particular groups of staff might prefer "*someone external, say from a hospice, in which case they would respect their specialist knowledge in palliative care*". An option to support those in similar settings might be to offer start-up training for teams or a cross-section of staff from one geographical area.

5.2.3 Most respondents had made some progress in taking ACP training forward

When asked what stage respondents were at in taking the ACP training forward, there was a similar pattern of responses at Phases 2 & 3 with around four fifths reporting they had made at least some progress, see Table F. By Phase 2 (October 2010), only a quarter of respondents had delivered some ACP training, although a further eight had arrangements underway for taking the training forward. The main difference by the time of the final survey in April 2011, was almost half of respondents reported that some ACP training had been delivered.

Table F – Responses from Phases 2 & 3 to the question 'What stage are you at in terms of taking ACP training forward?'

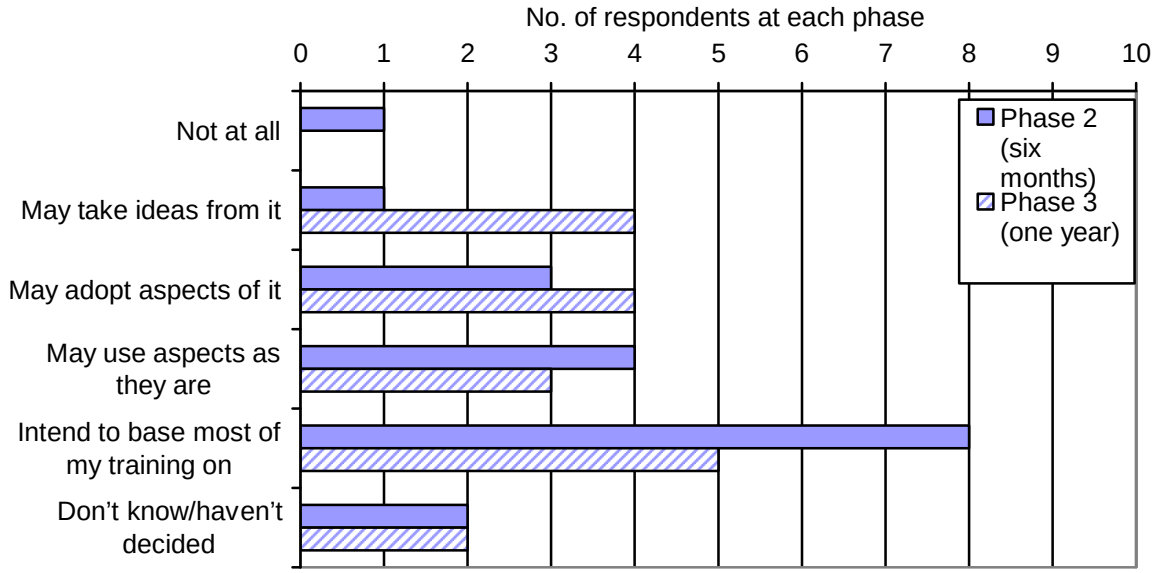
Stage	No. of respondents at Phase 2	No. of respondents at Phase 3
No progress as yet	7	7
Awareness raising only	10	11
Some local consultation on the ACP Facilitators' pack and/or meetings on how to adapt for local needs	4	1
I have ACP training sessions planned	8	0
Some ACP training has been delivered	9	17

There was still, however, around a third who had undertaken awareness raising only by the end of the first year, and almost a fifth who reported no progress with taking the ACP training forward. As noted above, for some this may have been a matter of confidence, other issues associated with time and leadership are discussed in Sections 5.4.1 and 5.5.

5.2.4 The facilitator's pack was still being used to help plan and deliver training a year after it was distributed

For those who were still at the stage of planning ACP training at Phases 2 & 3, Figure 5 shows that most intended to use or adapt the facilitator's pack to help with this. This suggests the contents of the pack continued to be seen as relevant to practice.

Figure 5 – Responses from Phases 2 & 3 to the question 'Do you intend to use the facilitator's pack when you deliver the training?'



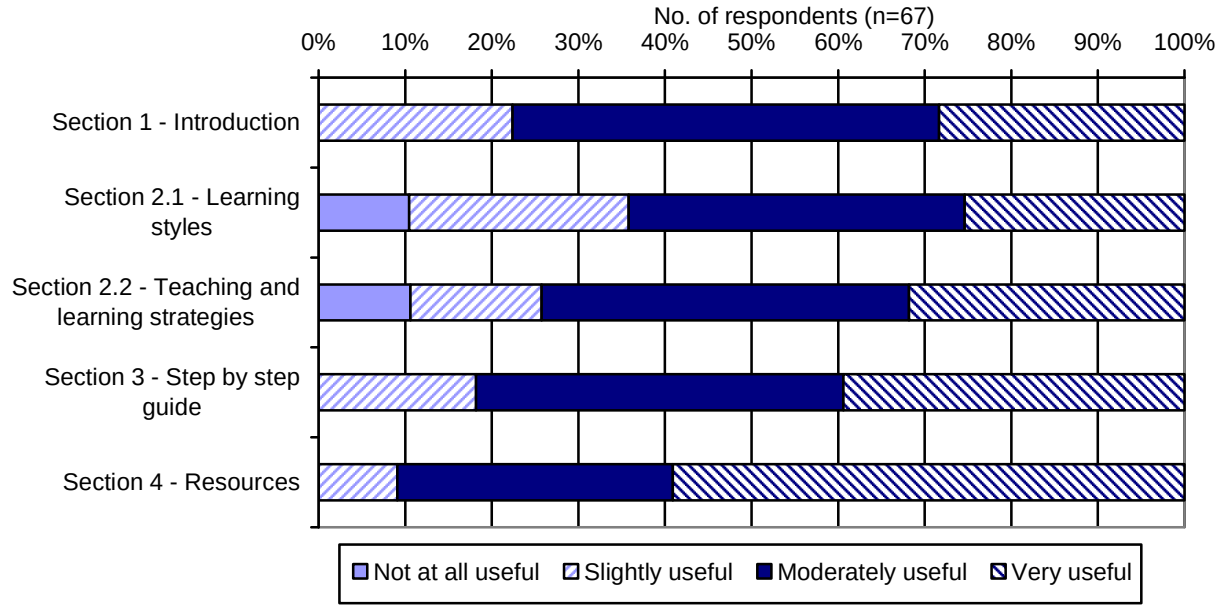
From those who had delivered training, a number described keeping the pack up to date, for example, by adding in "*articles about ACP, and local updates from the Long-Term Conditions manager*" noting that "*updating is important because the national picture is changing*" (3P008). This demonstrates that ACP Facilitators can and do keep these kinds of national training resources up to date, while also valuing having access to standardised training. It also suggests there is a demand for ongoing updates regarding ACP.

5.3 Objective 2: Investigate participants' perceptions of the learning materials and facilitators' resource

5.3.1 The training content was useful

The majority of respondents to the Phase 1 survey found the training content useful, see Figure 6. The most positive feedback was given on Section 4 (Resources) of the training content where 91% (n=60) of respondents found this moderately or very useful. Similarly, Section 3 (Step by step guide) was seen as moderately or very useful by 83% (n=54) of respondents. Respondents also indicated that the balance of the different sections within the facilitator's pack was about right.

Figure 6 – Responses from Phase 1 to the question 'How useful did you find the training content?'



5.3.2 The training day and facilitator's pack provided participants with much of what they needed

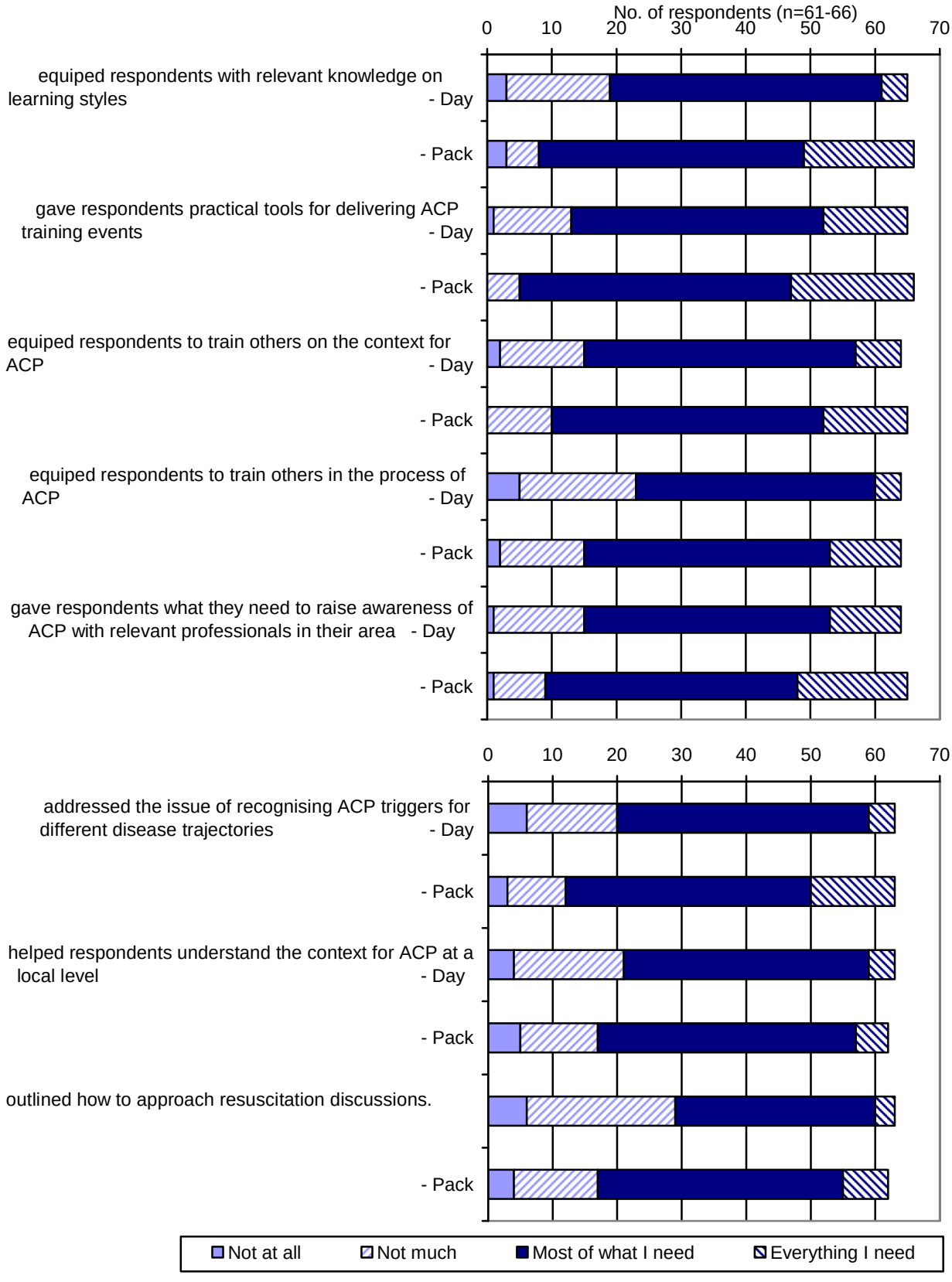
At the post-training stage, Phase 1, respondents indicated that the training, and facilitators' pack in particular, equipped them with most of what they needed across a range of factors pertaining to progressing ACP training, see Figure 7.

Topics that were slightly less positively received were the extent the training and pack had equipped facilitators to train others in the process of ACP, and helped them to understand of the context for ACP at a local level. This reflects earlier comments regarding ACP processes and documentation, and the availability of these at the time the training was delivered (Section 5.2.1). Recognising ACP triggers for different disease trajectories, and understanding how to approach resuscitation discussions also looked to be topics that Facilitators would have appreciated further resources on. Some of these have been addressed in the ACP Toolkit, which includes case studies of different patient scenarios[11].

Later on, comments from interviewees concerning the facilitators' pack included "*It's fab, really, really good*" (3P008) and "*NES did a wonderful job with the ACP facilitators' resources. The folder is a great resource for attendees*" (2P103). Some had taken the pack and 'stuck with it' with some adaptations (2P001), while others had not used it as intended "*because when we've done ACP training here, we've done it to suit our needs*" and had rather "*taken ideas from it*" (3P024).

[11] Advance & Anticipatory Care Planning Toolkit http://www.palliativecareinpractice.nes.scot.nhs.uk/advance-anticipatory-care-planning-toolkit/

Figure 7 – Phase 1 responses re the extent the ACP Training Day and Facilitators' Pack …



5.3.3 The training and pack were consistent with local policies, where respondents were aware of them

Respondents at Phase 1 reported that the content for the training and the pack were consistent with local ACP work. However, around a third did not know whether the training day and facilitators' pack were consistent with local polices, and there were cases where the training and pack were inconsistent with local ACP application. This may be partially down to the timing of when the training and pack were prepared, with national policies still in a state of change. Even so, during the later interviews, few could point to Board level strategies or documents relating to ACP training. (Also see Section 5.4.)

5.3.4 The 'ready to go' nature of the training resources was particularly valued

Phase 2 interviewees (who had all delivered training, or had sessions planned) noted the value of having "*a resource [the ACP pack] that you could use to set up and run a study day very quickly, without having to prepare all the materials and case studies*" (2P001). An opinion also reflected in this comment:

> "*The actual day itself was very good … Looking back on it, it's probably more the resources. The fact that someone sat down and thought about what we might need for this training and put the resource pack together, and we have the CD that we can use for our own training purposes, is quite good.*" (2P104)

Interviewees had made use of the pack. While some adaptations had been made, for example, where powerpoints were felt to be repetitive, there was an acknowledgement that "*if you weren't so experienced you might like more slides, to give more of a framework*" (2P001). Indeed, some interviewees felt that some of the suggested activities, such as the 'gold fish bowl role-play scenarios' would be challenging, "*without prior experience of facilitating that kind of learning activity … especially given the ACP context and you may have a multi-professional audience*" (2P001).

Other amendments included "*walking through the [local ACP] document within the day, because practitioners want to know how to document these conversations, where to put it, and how to share that information electronically*" (2P001). Indeed, there was a perception that the ACP Facilitator's Training came a bit early, with one interviewee highlighting that "*NES were tasked with producing an educational package for something that hadn't yet been worked through*" (2P089). Also see the discussion under Objective 5 regarding the use of different sections of the ACP Facilitators' Pack.

5.3.5 The training resources were being used in a variety of ways

Results from the Phase 2 survey showed that the ACP training materials had been incorporated into various types of training: as part of in-house training (n=13), short dedicated ACP sessions (n=9), longer dedicated ACP sessions (n=5), or as part of other courses (n=10).

One interviewee had mainly been using the pack to give advice, via informal training "*within my own team, with district nurses and within the heart failure team*" (2P104). This interviewee went on to note that one staff member had taken the pack away "*to have a proper look through it*". Again suggesting it has been well used for raising awareness. Other examples of how the training was used on the ground are given in the following sections.

5.4 Objective 3: Explore strategies adopted to deliver training within participants' NHS boards

The Phase 1 post-course completion survey asked a small number of questions relating to board support regarding ACP training. At that time, less than a third felt there was some or full support from their organisation to help roll out the training (29%, n=18), while a similar number felt there was little or no support (31%, n=19). For others, support from organisations was seen as taking the form of support for their own participation in the facilitator training (39%, n=24).

Many Phase 1 respondents felt their boards were still at the early stages, and some highlighted that clarification of responsibilities and further work on processes were required. Releasing staff to attend training was flagged as a potential issue. (See Table G for a summary of responses.)

Table G – Open responses from Phase 1 regarding how pro-active organisations were felt to be in supporting the roll out of ACP training

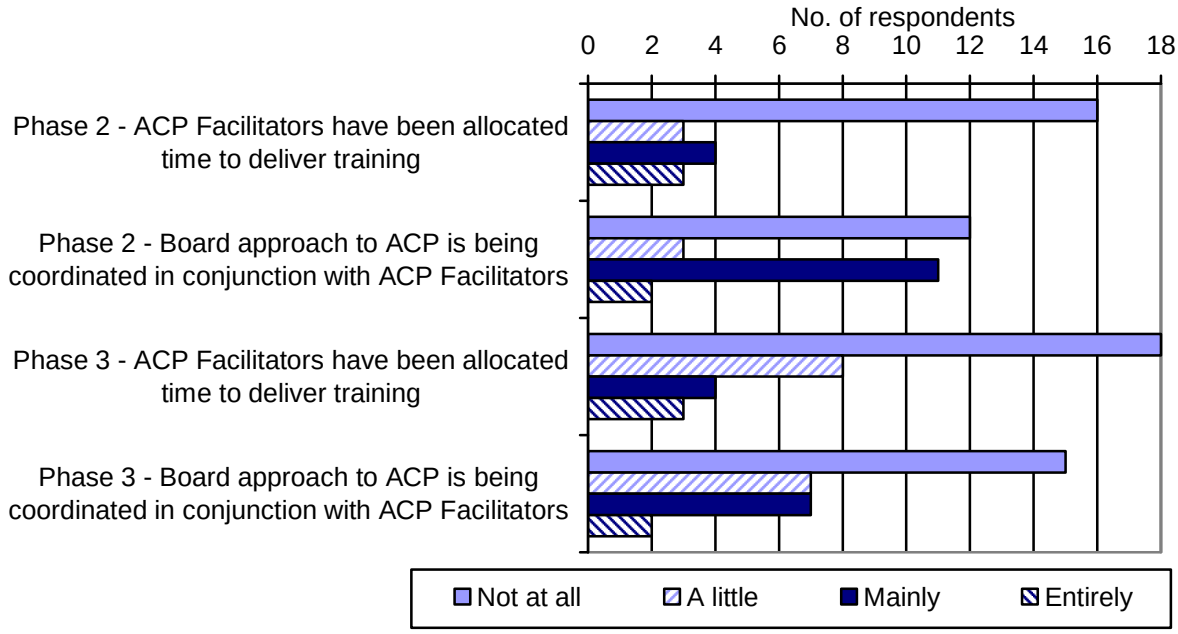
Topic area	No. of comments
Supportive – no plans for training, but awaiting clarification, discussion with senior staff	12
Could be pro-active, but dependent on individuals taking it on, time an issue	9
Parts of organisation looking at – links with palliative care teams, working on documentation and communication processes before implementing ACP training, incorporated into Chronic Obstructive Pulmonary Disease (COPD) clinical learning	9
Not ready	8
Highly supportive – through Long Term Conditions (LTC) agenda, strategic group looking at rollout across organisation	4
Not sure	4
Not at present, but needs have been highlighted with key stakeholders	2
Organisation keen but GP practices not signed up	1
A little but may improve in near future	1

Phases 2 & 3 included further survey and interview questions on how ACP was being addressed within NHS Boards. The findings from these are reported below.

5.4.1 ACP Facilitators have helped to coordinate the approach of some NHS boards to ACP, though many have no time allocated to deliver ACP training

Almost half of those surveyed indicated that they were involved in helping to coordinate their NHS board's approach to ACP, but more than half did not have time allocated to deliver ACP training, see Figure 8.

Figure 8 – Responses from Phases 2 & 3 to the question 'To what extent do the following apply to your NHS board or organisation?'



It was thus consistently reported in the Phase 2 & 3 surveys that the majority of ACP facilitators have not been allocated time to deliver training. This may relate to differences pointed out in interviews over the distinction between staff whose job it is to train others, and those who have more clinical responsibilities. This was reflected in a comment by one of the respondents to the Phase 3 survey:

> *"I am able to provide regular training sessions because that is my job - education. However I know I would not have been able to carry out the amount of sessions I have if I was in a clinical role."*

5.4.2 In some Boards, the position of ACP training is yet to be determined

Almost half of respondents in the Phase 2 & 3 surveys reported that ACP was being taken forward mainly or entirely in conjunction with Long-Term Conditions work. Although this also means the remainder reported ACP was only a little or was not being taken forward in conjunction with Long-Term Conditions work. Furthermore, two thirds of respondents reported that ACP was not being addressed or was only being addressed a little as part of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) training.

5.4.3 There are examples of ACP being integrated with other training and of cross-board co-ordination

One interview described how ACP had been incorporated across the piece, from being mentioned at induction, to inclusion in clinical update days, ACP awareness as part of journal clubs and "*an additional full day communication skills workshop looking at difficult conversations at the end of life looking to incorporate ACP and DNACPR*" (3P024). This seems like the ideal, however, this interviewee was based within a relatively small organisation and noted, "*the organisation decided it should be looking at ACP, which we did in the way I described and we ran the training and everyone attended. We're lucky in that respect*". This kind of systematic approach requires consistent support and strategic leadership, and would be much harder to implement in a large NHS Board.

One NHS Board had appointed a dedicated member of staff with specific responsibility for leading an ACP training project at pilot sites across the Board. A number of Phase 3 survey respondents and interviewees were aware of this. Indeed, the response to a query issued by NES on activity within Boards demonstrates that key roles have been assigned and these individuals feed into the Managed Clinical Network (MCN), so a joined up approach is possible.

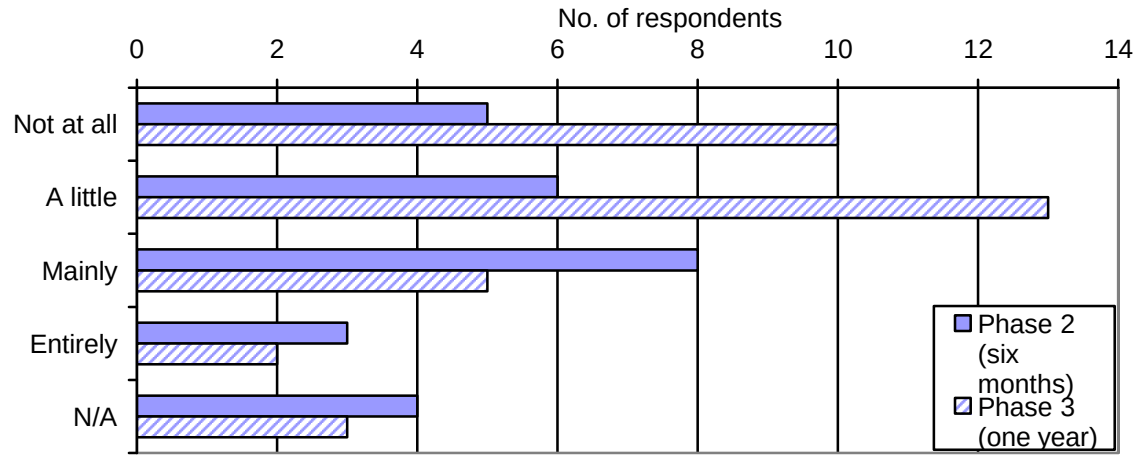
5.4.4 Identified leads did not always provide a focal point for ACP training

Respondents from other Boards reported that ACP did not have a dedicated resource but would need to be taken forward within existing resources. For example, *"Limited resource available to deliver ACP training across areas of board. ACP training has been predominantly delivered by palliative care service*" and "*Seems to have been left mainly with Specialist palliative care colleagues*" (Phase 3 survey respondents). Again, there were comments on the need for a focal point and strategic direction.

> *"ACP training has not progressed or commenced due to lack of direction from MCN/Practice Development Steering Group responsible for Palliative Care. To commence once Clinical Lead for Palliative Care is recruited into post."*
> (Phase 3 survey respondent)

As Figure 9 shows, the perceived role of Palliative Care Champions varied amongst the respondents, and varied at the two time points. (Remembering that a significant portion of the respondents to Phases 2 & 3 was drawn from different groups.) This may indicate a lack of clarity about how the Champions, or potentially other identified leads, relate to ACP training.

Figure 9 – Responses from Phases 2&3 to the question ''To what extent is the Palliative Care Champion leading on the rollout of ACP training in your NHS board or organisation?



5.4.5 Adjustments may be needed to reach some sectors, particularly regarding delivery time

At Phase 2, there was not much evidence of delivery to medical staff and there had "*not been a huge uptake from the acute sector*" (2P001). This may suggest that the approach to delivering training to these staff may have to differ from that laid out in the ACP Facilitator's Pack. One interviewee felt that ACP might have to be addressed alongside discussion of the ePCS and DNACPR, and that for GPs, 60 minutes might be more realistic. The suggestion was it needs to be stripped down into "*something that sounds palatable, otherwise staff are going to think if it takes a day of training then it's going to be far too much for me, because*

they'll think it is much bigger than it actually is" (2P089). Examples of ACP training for GPs had taken the form of a brief lecture to a large audience, and a 1 ½ hour session with 60 attendees. Thus a larger number might be targeted at once, but over a tight timeframe. Nonetheless, feedback from one interviewee suggested that nursing staff at least valued the opportunity to discuss different situations, "*it has to be a more practical approach, not just presentations*" (2P104).

5.4.6 Encouraging uptake of ACP training could involve identifying published benefits

Interviews at Phase 3 did, however, suggest that GP practices in some areas were actively seeking ACP training. "*Two years ago they were not interested. Now all [10 practices] are signed up, as they are now delivering the enhanced service, linked to QOF… All use the gold standards framework*" (3P008). In this case GPs had used their protected learning time session for the training. The value of multi-disciplinary sessions was highlighted as staff had attended in practice teams enabling "*discussion at the sessions that has worked through how practices will deal with particular situations*". This particular interviewee had clearly built up a reputation and demonstrated the value of ACP training over a period time. Others might gain from being made aware of potential hooks to encourage different professional groups to sign up to ACP training. For example, using resources related to the Gold Standards Framework[12] or published guidance on using the GP Contract Quality and Outcomes Framework (QOF) to improve end of life care in Primary Care[13].

5.5 Objective 4: Appraise the approach adopted in relation to supporting local delivery of education and training in ACP and organisational sustainability

5.5.1 Initially, the approach to training was viewed positively by almost all respondents

The initial reaction to the training was positive, with 97 % (n=61) of Phase 1 respondents reporting that the NES approach to building capacity by training facilitators to cascade ACP training was useful.

5.5.2 ACP training has been delivered over the course of the first year and further training sessions are planned for the second year

At Phase 2, 15 individuals from our sample of respondents who attended the ACP Facilitators' Training had used it to deliver 49 cascade training sessions to 426 people. By Phase 3, i.e. one year after the training sessions were completed, 17 individuals indicated they had delivered cascade ACP sessions. The 14 respondents who answered questions on the training they had run indicated that 83 training sessions had been delivered. Twelve of these respondents went on to say that they had delivered training to almost 700 people, and were planning to run a further 35 training sessions before the end of May 2011.

The potential for cascading the ACP Facilitators' Training is thus clearly demonstrated, although it would seem from the results after the first year that only a portion of the original course attendees have yet done so. Indeed, one year after completing the ACP Facilitator's

[12] National Gold Standards Framework Centre. (2011). *GSF in Primary Care.* Retrieved from http://bit.ly/lPQRqp

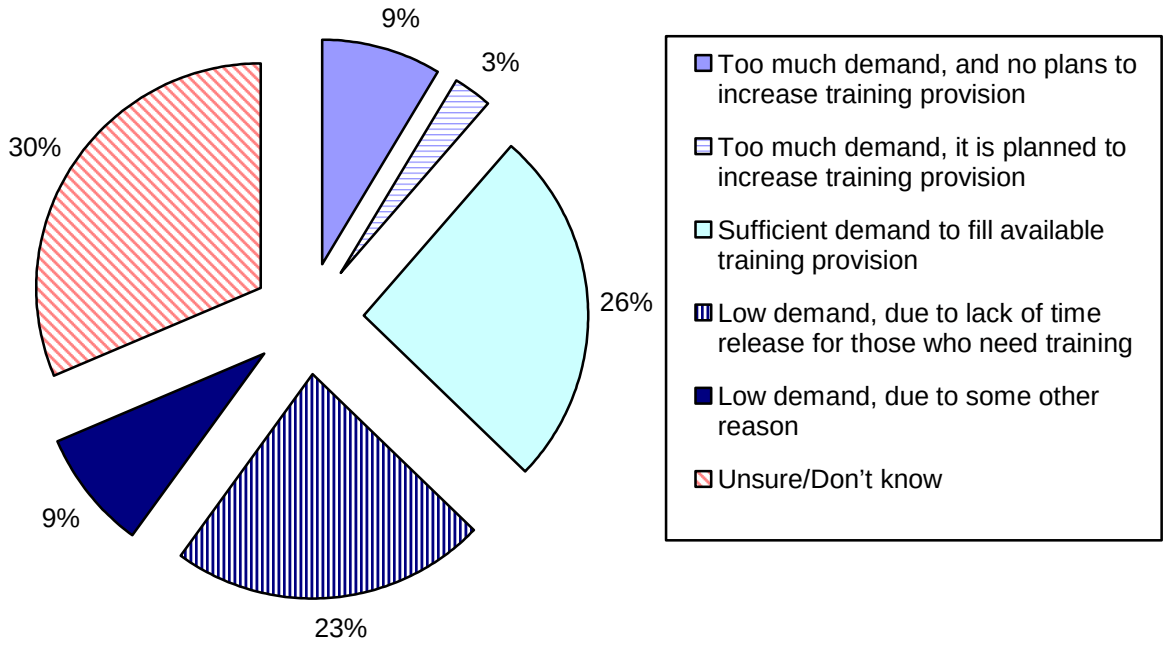
[13] Free, A., Thomas, K., Walton, W.-J., & Griffin, T. (2006, July). *Full Guidance on Using QOF to Improve Palliative / End of Life Care in Primary Care.* The Gold Standards Framework. Retrieved from http://bit.ly/lyTKll

Training, just over half of respondents (53%, n=19) had not delivered any cascade ACP training.

5.5.3 The level of demand for ACP training varies and many facilitators were unsure of demand in their NHS board or organisation

At Phase 2, one interviewee had found there to be "*more demand than we've been able to accommodate, partly because we're offering the training free … It's a hot topic, so people are interested*" (2P001). Another interviewee had also found it hard "*to contain it*" (2P103) with demand from colleagues in the charity sector. Phase 3 probed this further, and Figure 10 shows that respondents to the survey administered a year after the Facilitator's Training was complete described a variety of perspectives on the level of demand for ACP training.

Figure 10 – Perceived demand for ACP training within Phase 3 respondents' Health Boards (n=35)



The variety of responses almost certainly reflects the stage that individuals were at in terms of taking the ACP training forward; for example, those who had not delivered training might not be aware of demand. It would also relate to the respondents' role, some would be in a better position to gauge demand, as well as the approach of individual Boards.

Phase 3 respondents also gave open comments on perceived demand. The main factor thought to influence the level of demand was the number of competing priorities for staff time. This was reported as **restricting staff who wanted to deliver ACP training**. Examples of the time pressures on Facilitators included:

- *"Amalgamation of wards and departments, too much on to look at properly"*
- *"We will soon be adding ACP in to our education with Care Homes. Quite how this is to be achieved with all the others pressures on time and a reduction/skill-mixing of team remains to be seen."*
- *"I work 1 session per week ... it is difficult to arrange adequate training with this level of resource … Progress is slow in rolling out ACP Training."*
- *"Too few trainers in areas to provide the training that is required and the ongoing support and training that will be needed to maintain the high profile."*

There were also reports of **difficulties in releasing staff to take part in the training**:

- *"Constraints are releasing staff from acute sector for training"*
- *"Releasing staff is ongoing problem"*
- *"Too many other initiatives/ demands on time eg Releasing Time to Care etc."*
- *"Always difficult for clinical staff to be released."*
- *"Constraints are entirely financial as no monies for back fill to release staff for training."*

The constraints in releasing acute staff at one organisation have led managers to ask for *"that part of the training [to be] provided as an e-learning package. Communication skills and practice is not done via e-learning"*.

In some cases, demand for ACP training was also being **constrained by a lack of strategic coordination**:

- *"Lack of direction and co-ordination."*
- *"A clear strategy for rollout has still to be formally developed. Awareness raising sessions are sporadically available but not so much in acute care."*
- *"Not one approach, disjointed, lack of communication and nobody knows who the ACP facilitators are."*

The final reason suggested as affecting the level of demand and uptake of dedicated ACP training was a **lack of awareness**:

- *"I feel that low demand for training indicated low awareness of ACP and those who are aware of it think that it is someone else's responsibility"*
- *"At present, the majority of nurses are not aware of ACP and ACP training as a stand-alone topic. It is encompassed in all other aspects in Palliative Care."*

5.5.4 Local barriers to taking ACP training forward included lack of strategic direction, funding & time, and other local issues

As with the Phase 2 survey, a large majority (90%, n=16) of the respondents to Phase 3 who had ***not yet delivered training*** reported that there were local factors preventing the ACP Facilitators' Training being taken forward. The reasons reflect the influences on demand reported in Section 5.5.3. The barriers to taking training can be grouped into three themes.

1. **Leadership and strategic direction.**

Comments at Phase 2 included:

- *"No strategic leadership."*
- *"A strategy to rollout has not yet been devised but this is at the planning stage."*
- *"Need agreement to ensure consistency in training and agreement of how documented and communicated."*

Comments at Phase 3 included:

- *"Still no agreement and more importantly support for roll out of ACP training"*
- *"No firm decision agreed about ACP documentation across health board area"*

2. **Funding and time.**

Comments at Phase 2 included:

- *"Funding to release people to do the training and funding for backfill of course participants."* and *"Clinical time pressures. Team changes. No backfill."*

Comments at Phase 3 included:

- *"Staffing resources, Time resources"* and *"No Funding"*

3. Local specific issues.

Comments at Phase 2 included:

- *"Redesign of services."*
- *"Still implementing the LCP with acute hospitals and the fact that boards have decided to release staff over the winter months for mandatory training only."*

Comments at Phase 3 included:

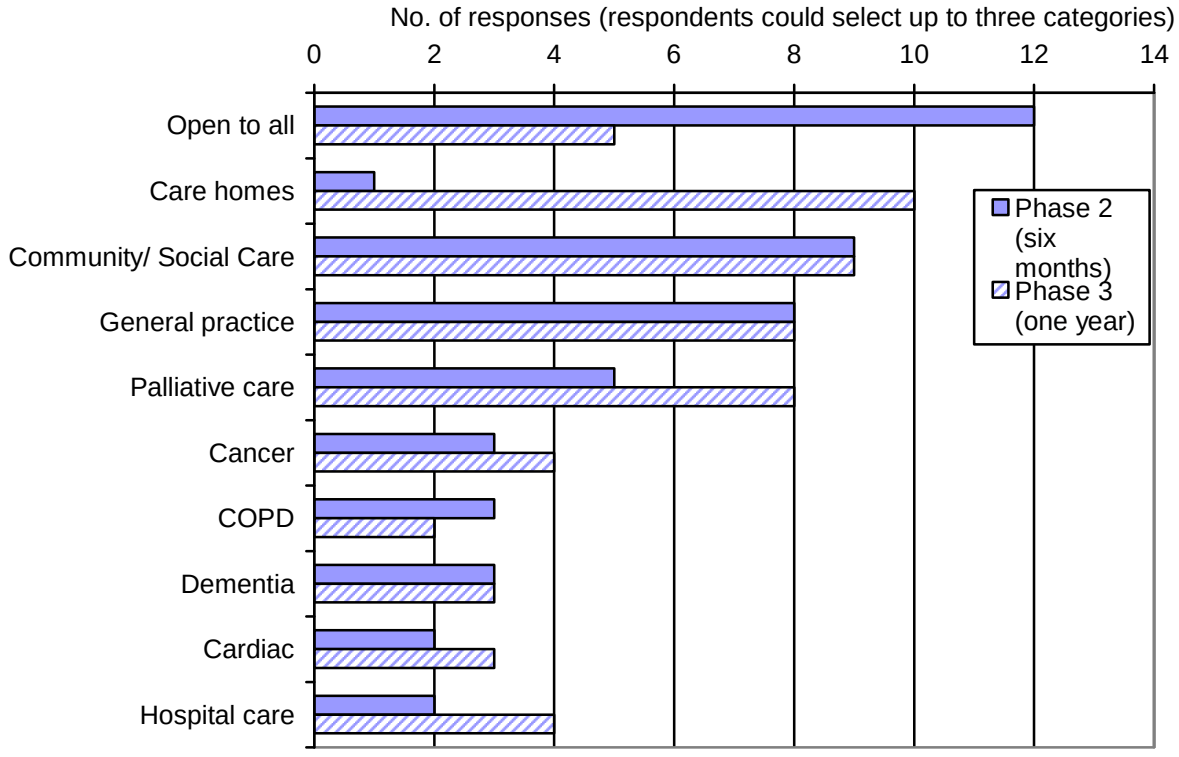
- *"Phased move to new hospital"* and *"Wards amalgamating"*.

5.5.5 There was a marked difference in the target audience for the training sessions reported over the first six months and that reported at one year

As Figure 11 shows, most ACP training during the first six months was open to anyone, with this sample particularly interested in targeting community/social care and General Practices.

Of the 15 respondents who answered the same question a year after the ACP Facilitators' Training, only one third reported that the training was open to all interested parties and two thirds reported that training was being targeted at care homes. Although it should be remembered that there was a difference in who responded to the Phase 2 & 3 surveys.

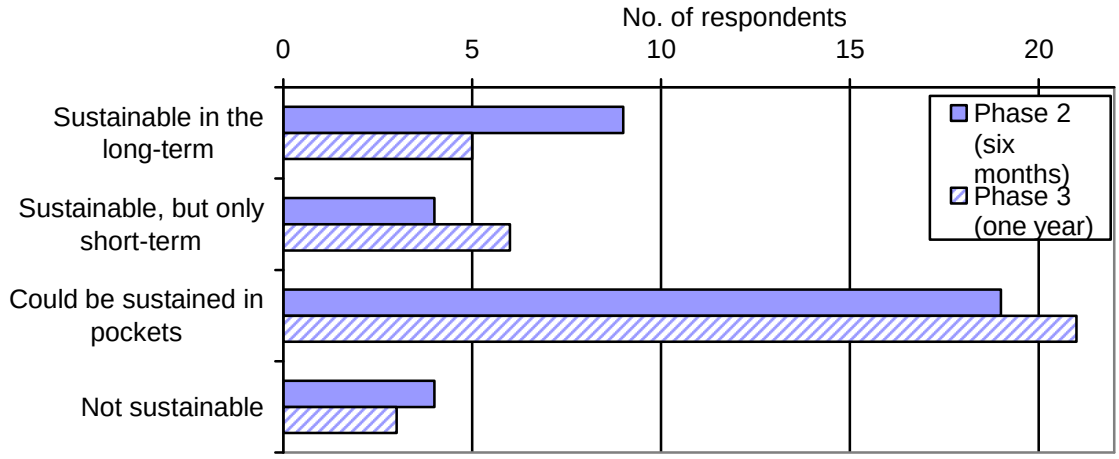
Figure 11 – Phase 2 & 3 responses of those who had delivered or planned training regarding specialities of the target audience for the training.



5.5.6 The majority of respondents thought the cascade approach to ACP training could be sustained in pockets, less saw it as sustainable longer-term

Figure 12 shows that over half of respondents who gave their views at both the six and 12 month stages thought the model of funding ACP Facilitators' training with the intent of then cascading ACP education locally could be sustained in pockets. Relatively few saw it as sustainable in the longer-term. A small number of respondents thought that this approach was not at all sustainable.

Figure 12 – Phase 2 & 3 responses to the question 'NES funded the ACP Facilitators' training with the intent that ACP education and training would be cascaded locally. How sustainable do you feel this approach is within your organisation?'



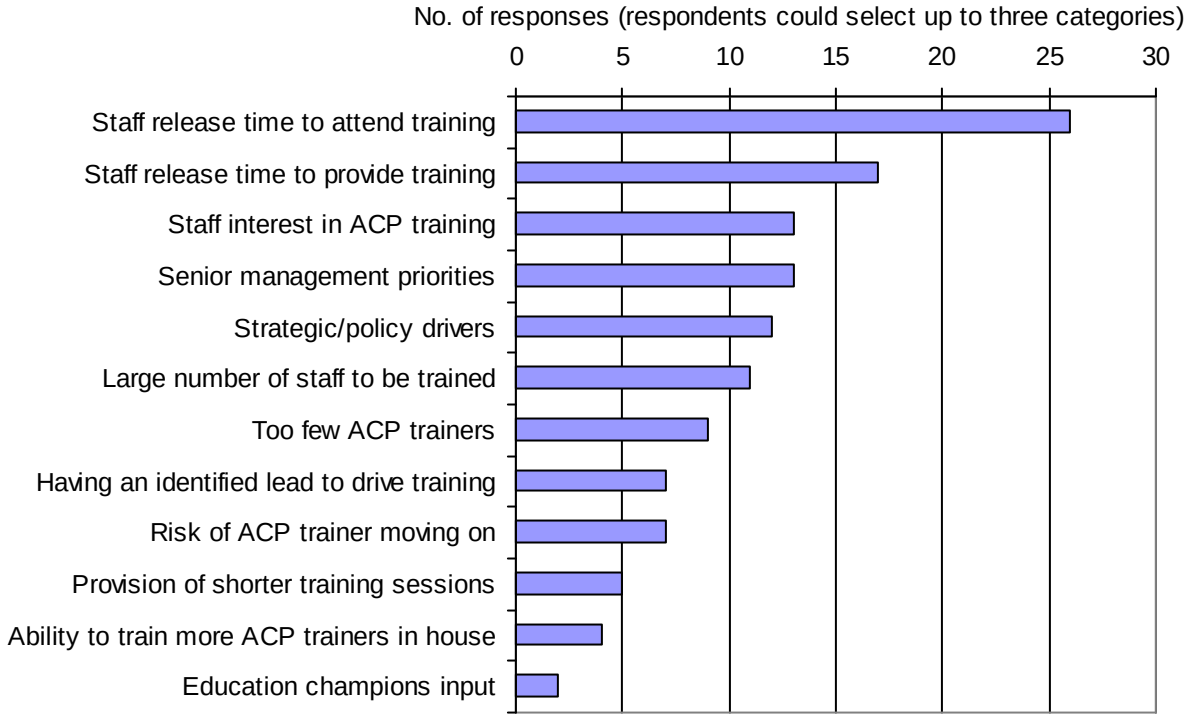
5.5.7 For some, partnership working helped to support the cascading model

To encourage further cascading, one group of facilitators had made it "*a condition of attending the training that [care home] staff have to take it forward, either fill in the forms or teach someone else*" (2P025). For this interviewee partnership working was key, with the ACP training supporting initiatives such as Local Authority care homes deciding to undertake ACP for all new clients. Another example was an interviewee meeting with social work trainers, who had subsequently "*taken the pack away and are making it simpler, then will be cascading it for social care staff*" to supplement palliative care training (2P025).

5.5.8 Releasing staff to deliver and to attend training is the key vulnerability in cascading ACP training

In the final round of the survey, more than three quarters of those who reported on the key factors affecting local sustainability highlighted that staff release time to attend training was important, see Figure 13. Half of respondents reported that staff time to provide training could also affect sustainability of the programme. (Reflecting comments made above concerning matching demand for training, see Section 5.5.3.) Figure 13 shows that around a third of respondents felt the sustainability of this training programme could also be affected by: staff interest in ACP training; senior management priorities; strategic/policy drivers; and the large number of staff requiring training.

Figure 13 – Phase 3 responses to the question ' What key factors could affect the sustainability of cascading ACP training within your organisation?'



In their open comments to this question in Phase 3 and a Phase 2 question on sustainability, respondents repeatedly highlighted two interrelated issues that could affect the sustainability of ACP training.

1. The **extent that ACP training is prioritised** against other competing demands. One respondent encapsulated many others' comments:
   "I think it is sustainable if the organisation believes this is important for patient care and support the education. And this message is cascaded from the most senior level down. It has been sustainable so far because two of the facilitators are employed to carry out education. There would not have been the numbers of attendance if this were not the case. So asking clinically active individuals to deliver training is dependent on their resource and patients' care will always take a priority."
   Within this, there was also reference to other training initiatives that take up staff time and attention, for example, "*ACP training is being rolled out in the community [but] staff are also involved in Releasing Time to Care training. Any more would be difficult to sustain until after the autumn*". There was also recognition that "*ACP is only one training need in palliative care and LTC*".
   Overall, this demonstrates that senior management buy-in and support is required, and that potential conflicts with other high priority training should be considered and avoided where possible.

2. The **extent that staff time was freed up to deliver or attend training**. Many respondents were looking for support and direction, but in some cases this appeared to be lacking, for example, the Facilitators' "*training has been useful but no commitment included or time allocated to take this forward. No contact from Education Champion to implement rollout*".
   Comments also reflected the earlier observation regarding whether or not ACP Facilitators

had education as part of their role. For example:
"*Cascade education is difficult in terms of people being able to be released to plan and organise training. Our experience of train the trainers is that unless [staff] have a training role within their remit they have great difficulty in delivering.*"
For those in a clinical role, patient contact and care took priority, especially within the acute setting:
"*Difficult to say for certain but sustainability is likely to be difficult in the acute setting due to large numbers of staff to be trained, current shortages and staff getting out of wards to be trained and due to other commitments that staff have to balance. It is also something that needs to be high on the agenda from senior management down through ward level.*"

Reflecting earlier comments, see Section 5.4.3, respondents also suggested that ACP training was easier to run in a sustainable way in smaller hospice-type settings and much more challenging when considered across an NHS board. It would "*require vision, planning and direction across (the NHS board). It will be no problem cascading within the hospice setting but has an impact on primary care teams also"*.

Respondents indicated that for the ACP training to be sustained in the longer term, it would need to be consistently reviewed and reinforced across health care settings. As "*based on previous initiatives using this approach, if the focus is not kept on ACP cannot see it being universally sustained by the health board"*. The training itself would also need revisiting "*to promote ongoing awareness and sustainability*". One respondent suggested "*ACP training should be mandatory over a specific timescale - say every 2 - 3 years with updates/education available for new staff"*.

Finally, it was acknowledged that over time there is potential for ACP itself to save money, by improving the quality of care and reducing hospital admissions. In the short term, however, it requires resource to implement ACP training, and funding was seen as a barrier to sustainability.

5.5.9 NES could consider a number of additional ways to support further cascading of ACP training

In the final survey, over 90% of respondents (n=27) indicated that if NES provided ACP resource packs for practice teams, these would be used to enable the further cascading of training. Three quarters (n=21) also wanted NES to facilitate sharing of ACP processes and documentation. Almost two thirds (n=19) thought it would be helpful if NES provided opportunities to pair with a more experienced ACP Facilitator to deliver initial training sessions. Other ideas such as: enabling sharing of experience via online forums; further guidance on setting up an ACP 'train the trainer' system; support to tailor materials; or running more or regular ACP Facilitators' courses were supported by around half the Phase 3 respondents (n=13).

5.6 Objective 5: Investigate experiences of participants in delivering ACP education and training (including successes and challenges)

5.6.1 All sections of the Facilitators' training pack are being used in preparing subsequent ACP training

Phases 2 & 3 respondents who indicated they had used the ACP Training Pack reported using different sections to help prepare and deliver ACP training. The chapters on "What is ACP?", "ACP: Timings & Triggers", and "Case study examples" were included by almost two thirds of facilitators in their training sessions. Indeed, interviewees often referred to delivering training around case studies that trainees worked through themselves. For example, *"we did it as a case study that [people] built up throughout the session and was tailored to meet our needs, and people could interact with our own documentation*" (3P024). The chapters on "Ethical decision making", "ACP: Communication Skills Theory", and "ACP: Communication Skills Practice" were included by just under half of Phase 3 respondents. The chapters on "Learning Styles" and "Teaching and Learning Strategies" were more often used to help in preparation for the delivery of training rather than in the training content itself, as would be expected.

Phase 3 survey respondents indicated the Facilitators' Training Pack was also being used to help with other training, not just on ACP. For example, *"the concepts are applied to other palliative care training*" and "s*ome of the slides were useful in broader communication skills training"*.

As already evidenced, see Section 5.5.7, the materials were also being shared more widely so that others could use them to plan training specific to their own setting. One Phase 3 survey respondent had *"shared the resources with social work and mental health colleagues so that they can plan their own day*".

5.6.2 Additional materials have been developed to supplement the ACP training

Many of the respondents who indicated they had used the ACP training had also developed local materials to supplement those included in the Facilitators' Training Pack. For example, one had developed *"an ACP document (based on 12 core component guidance) for generic use, an information leaflet & SBAR [Situation-Background-Assessment-Recommendation] Communication Tool"*.

Responses to the Phase 2 & 3 surveys consistently demonstrated that respondents, or their Health Boards, had developed guidance on local ACP documentation (around half of those who had used the ACP training at Phase 3). A consistent picture also emerged that around two fifths of respondents had developed additional materials in relation to DNACPR. The focus on DNACPR may relate more to current national and board priorities, than to perceived or actual requirements regarding ACP training on the ground.

The final round of the survey indicated that around a third of respondents (n=10) thought there was a need for additional resources to be developed on "Legal guidance regarding ACP" and also "ACP material for specific conditions". The need for clarification over legal issues had also been raised in Phase 2 interviews. Other suggestions for additional materials included requests for a *"DVD showing examples of ACP conversations that are not related to DNA CPR"* and a *"Booklet for patients such as EOLC 'Planning for your future care'"*.

5.6.3 Training based on the ACP Facilitators' Pack was well received

In both the Phase 2 & 3 surveys, 14 respondents who had delivered training using the ACP Facilitators' Training Pack gave feedback on the different sections within the pack. All those who used the chapter on "What is ACP?" and "ACP: Communication Skills Practice" reported that this had been very well or well received by the audience. A large majority also reported the sections on "ACP: Timings & Triggers" and "Case Study Examples" as being very well or well received. The sections "ACP: Ethical decision-making" and "ACP: Communication Skills Theory" were generally well received but did not rate quite so positively.

5.6.4 The majority of those who had facilitated or planned ACP training reported that they did not need further training on ACP

At Phase 2, four of those who had facilitated or planned training for others reported that they felt they needed further ACP training. In the final survey at Phase 3, only two respondents reported a need for further training. The main areas identified for further training were around the legal and ethical aspects of ACP, and on regional updates. This suggests the ACP Facilitators' Training did indeed meet the needs of those delivering training. This does not necessarily represent the needs of those who had not delivered ACP training, and as indicated earlier it is likely that they may need additional support.

6 Conclusions

Overall, the training met the majority of respondents' expectations and it had increased knowledge and confidence amongst those intending to facilitate ACP training. The training pack provided most of what facilitators needed, and it was being used either as is or with local adaptations. The materials had been well received by training audiences. The pack had also been handed on to others to develop training in their own context. In relation to strategies adopted by Boards, it appeared that for some, the position of ACP training is yet to be determined. There were examples of cross-board collaboration and integrated delivery of ACP, though it was recognised this is more feasible in settings such as individual hospices rather than within the larger NHS Boards.

The potential for cascading the ACP facilitators training has been demonstrated, although it would seem from the results after the first year that only a portion of the original course attendees have done so. Local barriers to taking ACP training forward included lack of strategic direction, funding and staff time; though these are issues that could apply to any training initiative. Releasing staff to deliver and to attend training is the key vulnerability in cascading ACP training. Conclusions pertaining to the findings of the study against the five evaluation objectives are presented below.

Objective 1: Assess the relevance of the ACP Facilitator Training to participants' own practice

- The training met the majority of respondents' expectations.
- The training increased most respondents' knowledge and confidence in facilitating ACP training.
- By Phase 2, over half of facilitators had used the ACP Facilitators' Training and/or Training Pack to raise awareness with colleagues, which suggests in this respect at least the training was seen as relevant to practice.
- Most respondents had made some progress in taking the ACP training forward. It seems likely that for those who had not delivered ACP training, barriers relate to time allocation, lack of strategic direction or some local issue, rather than the ACP Facilitators' Training itself.
- Most of the respondents who had yet to deliver ACP training indicated their intent to use the Facilitators' Training Pack.
- The Facilitators' Training Pack was still being used to help plan and deliver training a year after it was distributed.

Objective 2: Investigate participants' perceptions of the learning materials and facilitators resource

- The ACP Facilitators' Training content was useful.
- The ACP Facilitators' Training Day and Training Pack were reported as providing participants with much of what they needed.
- The training and pack were consistent with local policies, where respondents were aware of them.
- The 'ready to go' nature of the training resources was particularly valued.
- The training resources were being used in a variety of ways

Objective 3: Explore strategies adopted to deliver training within participants' NHS boards

- ACP Facilitators have helped to coordinate the approach of some NHS boards to ACP, though many have no time allocated to deliver ACP training.
- The position of ACP training is yet to be determined, in some Boards at least.
- There are examples of ACP being integrated with other training and of cross-board co-ordination.
- Identified leads did not always provide a focal point for ACP training.
- Adjustments may be needed to reach some sectors and professional groups, particularly regarding delivery time.
- Encouraging uptake of ACP training could involve identifying published benefits, such as resources related to the Gold Standards Framework[14] or published guidance on using QOF to improve end of life care in Primary Care[15].

Objective 4: Appraise the approach adopted in relation to supporting local delivery of education and training in ACP and organisational sustainability

- Initially, the approach to training was viewed positively by almost all respondents
- ACP training has been delivered over the course of the first year and further training sessions are planned for the second year. The potential for cascading the ACP Facilitators' Training has thus been demonstrated; although it would seem that only a portion of the original course attendees have done so.
- The level of demand for ACP training varies and many facilitators were unsure about the level of demand in their NHS board or organisation.
- Local barriers to taking ACP training forward included lack of strategic direction, funding & time, and other local issues.
- There was a marked difference in the target audience for the training sessions reported over the first six months and that reported at one year post-training.
- The majority of respondents thought the cascade approach to ACP training could be sustained in pockets, less saw it as sustainable longer-term.
- For some, partnership working was key to the cascading model.
- Releasing staff to deliver and to attend training is the key vulnerability in cascading ACP training.
- NES could consider additional ways to support further cascading of ACP training.

Objective 5: Investigate experiences of participants in delivering ACP education and training

- All sections of the Facilitators' training pack are being used in preparing ACP training.
- Additional materials have been developed to supplement the ACP training. Most in relation to DNACPR or on more specific local guidance on ACP. The focus on DNACPR may relate more to current national and board priorities, than to perceived or actual requirements regarding ACP training on the ground.
- Those who had already delivered training reported three sections of the ACP Facilitators' Training Pack as being particularly well received, namely What is ACP?, ACP: Timings & Triggers and the Case Study Examples.
- The majority of those who had facilitated or planned ACP training reported that they did not need further training on ACP.

[14] National Gold Standards Framework Centre. (2011). *GSF in Primary Care.* Retrieved from http://bit.ly/lPQRqp

[15] Free, A. et al (2006, July). *Full Guidance on Using QOF to Improve Palliative / End of Life Care in Primary Care*. The Gold Standards Framework. Retrieved from http://bit.ly/lyTKll

7 Recommendations

Recommendation 1. The evaluation found that the sustainability of the training was dependent on the extent to which ACP training was prioritised against other competing demands. The Scottish Government and NHS boards could undertake an analysis of outcomes linked to ACP (with indicators relating to quality of care, efficiency savings, shifting the balance of care). This would provide direct evidence of the value of ACP, to inform the Scottish Government and NHS boards, and thereby support implementation. This could also help to ensure ACP is given appropriate importance in relation to competing policy and strategic drivers within health and social care.

Recommendation 2. The findings from this evaluation indicate that identified leads are not widely seen as leading on the rollout of ACP training, and in some cases were not providing the steer that ACP Facilitators were looking for. NES may wish to consider how it takes forward this work with NHS Boards, as well as local Palliative Care Executive Leads, to ensure that ACP training is included in educational strategies and promoted within each NHS board and across different professional groups.

Recommendation 3. The evaluation reported that the level of demand for ACP training is uncertain. In order to ensure that those who need ACP training are able to access it, local educational plans should outline clear strategies for addressing ACP training needs by: offering clear guidance on which professions and staff groups require ACP training; building an accurate picture of demand for ACP training; and ensuring adequate training resources are available to meet this demand. This should inform a more strategic approach to ACP training and ultimately promote equity of care.

Recommendation 4. The evaluation findings indicate that more than half of those trained as ACP Facilitators did not have time allocated to deliver ACP training. If ACP training is to be sustained over the longer-term, NHS boards should look at the best way to use existing resources to ensure that Facilitators have dedicated capacity to deliver training. Future initiatives of this type would benefit from support both for the initial training of Facilitators, but also the subsequent rollout of training to staff.

Recommendation 5. The evaluation findings indicate variation among NHS boards in how ACP relates to other workstreams, such as DNACPR, with the potential for gaps or duplication in training provision. NES may wish to work with NHS boards to consider options for improving integration of ACP across its different workstreams such as long-term conditions, reshaping care for older people, and dementia.

Recommendation 6. There was a general consensus that national training delivered in this format, i.e. with face-to-face training accompanied by a 'ready to go' facilitator pack is an efficient and effective approach. It was also seen as having the added advantage of standardising training across Scotland. With due consideration of the number of training rollouts per year, it would seem valuable to continue with this approach.

Recommendation 7. Rolling out training linked to national policy initiatives presents challenges in terms of timing, particularly when the processes and systems associated with such policies require discussion and development at a local level. In this case, many ACP Facilitators received training before ACP processes and documentation were in place within their boards. While this meant the ACP resource pack could be used to inform local policy discussions, the evaluation also reported a number of requests from Facilitators for guidance on the ACP process. This suggests that including examples of basic process documentation and/or highlighting how local documentation could be incorporated into training would have been a valuable addition. Future initiatives of this type might benefit from a separate stream of work that reviews potential processes from elsewhere, collates relevant frameworks or pathways, and summarises these to convey the likely components required of the system.

Recommendation 8. One of the main barriers to cascading ACP training identified by the evaluation was the limited extent that staff time was freed up to attend training. This issue is not specific to ACP training but reflects the time pressures experienced by many health and social care staff, and the lack of resources to provide cover for training courses. This means flexibility in training delivery is vital. While experienced facilitators will be able to adapt the ACP resource pack to deliver shorter training sessions to suit staff who are unable to attend a whole day of training, it would further minimise preparation time if future Facilitators' packs suggest programmes with a range of training session times. Other options relating to the use of e-learning and blended learning approaches could also be supported (Recommendation 10).

Recommendation 9. The evaluation reported that ACP Facilitators would make use of additional help to cascade ACP training. NES may wish to consider how it continues to support Facilitators across Scotland by activities such as: promoting the resource pack; enabling sharing of ACP processes and documentation; and promoting opportunities for ACP trainers to learn from each other through joint delivery of training.

Recommendation 10. NES could also consider how best to support the uptake of other formats for the delivery of ACP training. For example, by further promoting the End of Life Care for All e-learning (e-ELCA) [16] materials, especially as access for NHS Scotland staff has been agreed; and encouraging Facilitators to make use of the new ACP toolkit[17] and Palliative and End of Life Care Work-Based Learning Resource[18].

[16] e-Learning for Healthcare. (2011, April). E-learning for End of Life Care (e-ELCA) Curriculum workbook (which lists the units of learning available). http://www.e-lfh.org.uk/docs/projects/e-elca/CurriculumworkbookforeLfHwithdisplayIDsApril2011.pdf

[17] Advance & Anticipatory Care Planning Toolkit http://www.palliativecareinpractice.nes.scot.nhs.uk/advance-anticipatory-care-planning-toolkit/

[18] Palliative and End of Life Care Work-Based Learning Resource http://www.palliativecareinpractice.nes.scot.nhs.uk/palliative-end-of-life-care-work-based-learning-resource/

Recommendation 11. Some ACP Facilitators indicated they were collating additional ACP resources. This was to supplement the resource packs, but also to forward to those who attended their training in order to continue to raise awareness of ACP. Some of these resources pertained to local policy documents, but there are other national developments and initiatives, and learning resources that NES could usefully highlight to ACP Facilitators. A range of resources has been brought together in the ACP toolkit, but it would help to maintain the profile of ACP if new resources continue to be highlighted. This could be achieved via the Palliative Care Education Managed Knowledge Network (MKN)[19] or could be brought to the attention of ACP Facilitators directly via email.

Recommendation 12. As this stage of the ACP Facilitators' Training project comes to a close, it seems likely that a strategy for ongoing communications regarding ACP would be beneficial. The Palliative Care Education MKN would seem a useful channel to disseminate information, though not all those who attended the ACP Facilitators Training are members. Maintaining the MKN, and encouraging further uptake, would require at least some dedicated resource.

[19] Palliative Care Education MKN http://www.knowledge.scot.nhs.uk/palliativeeducation.aspx