Health Education Yorkshire and the Humber funded training significantly increases practice based Advance Care Planning in settings across the district. More people supported to have their preference for end of life care discussed and recorded.

**Background**

By providing a whole system approach to Advance Care Planning, with a dedicated programme and trainers, the number of patients supported to think about and have their choices recorded through Advance Care Planning has increased across the district.

Wakefield is an industrial city within West Yorkshire, a largely white British ex-mining community with a population of approximately 306,500. There are three hospitals with all the district community services within the NHS Trust, and 40 GP practices.

Health Education Yorkshire and the Humber funded a project, responding to an identified key area of need, to:

- Increase the percentage of patients who die in their preferred place of care/death (PPC/PPD)
- Improve anticipatory prescribing for symptom control
- Enhance staff skills, knowledge, confidence and competence
- Increase the number of patients with an Advance Care Plan
- Reduce inappropriate investigations and treatments
- Reduce inappropriate hospital admissions.

The project runs concurrently with the EPaCCS (electronic systems to help co-ordinate end of life care for people), project launched on 1 April 2014.

**Approach**

Two End of Life Care Education Facilitators (1.60 whole time equivalent) were employed for 18 months from March 2014. A Macmillan Consultant in Palliative Medicine and a GP End of Life Care Lead were provided to support them.

The remit was to provide practice based training in Advance Care Planning for clinical teams within Mid Yorkshire Hospitals, Wakefield District Community and Wakefield GP practices. As at June 2015, over 900 doctors, nurses and allied healthcare professionals have connected with the programme, with additional training planned to the current project end in September 2015.
The approach taken includes:

- Networking across the region to share resources and experiences
- Building relations with key clinical and other influencers to gain opportunities to train different staff groups (for example, working with and through local contacts the team connected with local hospital ward sisters). This significantly helped in better understanding hospital structures during times of change
- Devising training packages that could be delivered in any setting, i.e. on the wards, GP practices, lecture theatres and offering flexibility on timing
- Taking every opportunity to deliver at local and regional events
- Using Clinical Commissioning Group and Trust newsletters/bulletins to advertise the training available
- Pre-learning individual surveys to establish a baseline
- Employing learning approaches to engage staff such as a Pub Quiz and Circle of Life board game: http://tinyurl.com/ncz43hs
- Including a “Train the Trainer” option.
- Drawing on up-to-date national reports and initiatives e.g. Dying Matters Week
- Ongoing evaluation of training and methods, with a report completed and shared with Wakefield CCG, Health Education Yorkshire and the Humber, the Chief Executive Officer and the Board of Trustees at Wakefield Hospice, Chief Nurse/Deputy CEO of The Mid Yorkshire Hospitals NHS Trust and the Regional End of Life Education Facilitators Forum.

Overcoming potential acute staff release challenges

The team recognised winter pressures can sometimes prevent Trust staff being released from clinical areas; they also understood how important it was to consider Trust staff levels. During the winter the team took a flexible approach and concentrated on training specialist teams and GP practices, helping to avoid having to cancel ward based training.

Reflections on the project and what worked well

Working independently from the Specialist Palliative Care (SPC) team had advantages. It allowed the opportunity to network freely, explore different ways of training and offer flexibility in venues and audience requirements. The opportunity to deliver broader palliative care training would also be an advantage. Having no patient care responsibilities allowed the team to commit to the project 100%.

The team continually evaluated the training and used post training questionnaires. As a result of the feedback gained the initial amount of planned training time for each session was increased.

Following the training a clinical nurse specialist team now incorporate Advance Care Planning in their assessment process in the outpatient department. Furthermore, a community pharmacist has been able to facilitate this for patients in the community with positive outcomes.

The team observed that when they concentrated training on hospital teams the community figures for patients who have an Advance Care Plan were decreasing but have now increased again.

Sample learner feedback included:

“I found this a valuable session. I now feel much more comfortable speaking to patients and family/carers.”

“Very informative course delivered in a relaxed manner that allows for explanations and discussion.”
The impact shown across the community on understanding people’s wishes

Data in graphs 1 and 2 below are sourced from GP practices and community nurse palliative care registers.

**Graph 1: Comparison of pre training in 2013/14 and post training 2014/5**

- Deaths recorded on registers to support positive end of life care: 733 (2013/14) vs 700 (2014/15)
- Advance Care Plan/conversations documented: 18 (2013/14) vs 428 (2014/15)
- Wish to attempt or not attempt CPR recorded: 0 (2013/14) vs 597 (2014/15)
- Preferred place of death recorded: 0 (2013/14) vs 573 (2014/15)
- Actual place of death recorded: 0 (2013/14) vs 536 (2014/15)

**Graph 2: Comparison of pre training in 2013/14 and post training 2014/5**

- Deaths recorded on registers to support positive end of life care: 110 (Q1) vs 190 (Q4)
- Advance Care Plan/conversations documented: 65 (Q1) vs 192 (Q4)
- Wish to attempt or not attempt CPR recorded: 102 (Q1) vs 179 (Q4)
- Preferred place of death recorded: 91 (Q1) vs 169 (Q4)
- Actual place of death recorded: 90 (Q1) vs 180 (Q4)
It is important to remember each figure represents an individual person, their experience and that of those who matter to them.

These figures show an increasing number of patients have had the chance to think about and have their wishes for future care formally documented. This may mean that patients, with those who are important to them, have been able to be more involved in discussions around end of life care, and may be more likely to have their preferences for care met as a result.

One person said that her parent had an Advance Care Plan and because of this it had “made it really easy for me.”

Another said that their teenage grandchild was able to be involved in the funeral as they knew it was what their grandparent had wanted from the Advance Care Planning.

**Sustaining improvement**

The figures above suggest the training has led to a positive change in practice which benefits patients and those who are important to them.

While this project and its funding are time limited, there is good evidence to support a further future and sustainable programme of training.

The team’s substantial report (see [www.wakefieldhospice.org/Our-Services/Who-We-Are/Information-for-Professionals/Education-Resources](http://www.wakefieldhospice.org/Our-Services/Who-We-Are/Information-for-Professionals/Education-Resources)) includes several future recommendations.

Since this case study was developed, the programme is now due to be delivered in the Care Home Sector within Wakefield District on a part-time basis from September 2015 over the next 18 months with the agreement of all partner organisations.