
CONFERENCE ABSTRACT

Anticipatory Care Planning in Scotland

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Background: Innovative work is being undertaken across Scotland to reshape delivery of care. Effective Anticipatory Care Planning (ACP) is key to ensuring optimal delivery of an appropriate and sustainable model of health and care. This is supported through the use of information sharing technology, the Key Information Summary (KIS), to communicate across the primary and acute care interface.

The initiative is aligned with the NHS Quality Strategy for Scotland, the 2020 vision and the National Health and Wellbeing Outcomes supporting Health and Social Care integration.

At a time of significant change and challenge within our healthcare system there is a need to ensure provision of safe, high quality services at home or in a homely setting for people with disabilities, long term conditions or multiple morbidities. This is achievable by developing a robust community infrastructure with capacity and capability to optimise care and quality of life and manage more people more independently out of hospital.

ACP is a person-centred, proactive, "thinking ahead" approach, requiring services and professionals to work with individuals and their carers to set personal goals ensuring the right thing is done at the right time by the right person with the right outcome. ACP evolves reflecting the individual's situation and requires a supportive whole-system infrastructure to ensure delivery of positive outcomes. ACP provides opportunities to improve health literacy and understand personal health and care issues, circumstances and outcomes, enabling informed decision-making and expression of preferences.

The work responds to the challenge of providing care for an ageing population with increasing prevalence of long term conditions and multiple morbidities. Currently, in Scotland, 80% of individuals admitted to hospital are over 75 years. 30% of admissions could potentially be avoided through mainstreaming an ACP approach supported by a model providing appropriate case management, interventions close to home, signposting, access to supported self management, local intermediate care, enablement and rehabilitation.

Planning and improvement: A cross-sector *Anticipatory Care Planning Task and Finish Group* aligned with the *Living Well in Communities (LWIC)* initiative has developed a National Action Plan to support implementation of ACP principles across Scotland over two years to

deliver best-model, person-centred care close to home with consequent reduction in avoidable hospital admissions and bed days.

The National Action Plan: has been informed by continuous improvement work over the last decade to implement principles outlined by Kerr (2005) and learning from improvement through collaboration on reshaping care for long term conditions and multi-morbidities supported by local best practice initiatives.

Population stratification estimates that 5-6% of the population could potentially benefit from ACP. Vulnerable individuals should be identified and offered interventions in a timely way to enable informed choice and ensure optimise outcomes. ACP triggers based on situation, condition and assessment support ACP initiation. Triggers include falls, which account for 10% of unplanned admissions, polypharmacy and dementia.

2% of the population, (high-resource individuals), utilise 77% of hospital inpatient days and 50% of combined prescribing resources. There is potential to improve efficiency through collaborative work for this group.

Primary Drivers: The National ACP Action Plan focusses on 3 Primary Drivers (below) developed through extensive scoping work, improvement methodology informed by logic modelling and consultation with a wide range of stakeholders and service users.

1. Awareness-raising with public, services and organisations to embed ACP within each Locality to help those with multiple morbidities and ensure delivery of locally accessible services for those with most complex needs.
2. Carer support must be prioritised alongside ACP.
3. Provision of consistent ACP material to support individuals and appropriate information sharing between professionals to support collaborative work.

The Key Information Summary (KIS) currently hosted on the GP IT system enables eACP access. Following successful pilot work, engagement with General Practice and Primary Care has been established by integrating KIS and ACP with the Quality and Safety Domain of the GP Contract QOF. In Year One, 151,641 individuals (3.2% of the population) had a KIS. Through partnership working KIS is accessible to unscheduled care services including NHS 24, Out of Hours, Emergency Department and hospital front door resulting in 3.32m KIS accesses/annum outside general practice. 81% KIS contain information considered valuable to informing appropriate interventions. Ongoing work is focussed on evolution of KIS to enable greater accessibility and cross sector working.

Further improvement will also include an organisational scoping exercise, tests of change, learning needs analysis and developing an identifiable single "branded" Scottish ACP and national role out of a whole-system ACP model co-ordinated through a national ACP Partnership Network and communication strategy.

Keywords: person-centred; anticipatory care; information sharing
