Anticipatory Care Planning in Lanarkshire: the journey

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Long Term Conditions

People with 3+ long-term conditions up 100% to 2.9m by 2018

Scottish Health Survey 2008

- **40% of adults have a long term condition**
- **25% have a limiting long term condition**
- **I in 3 aged 75+ have two or more LTCs**

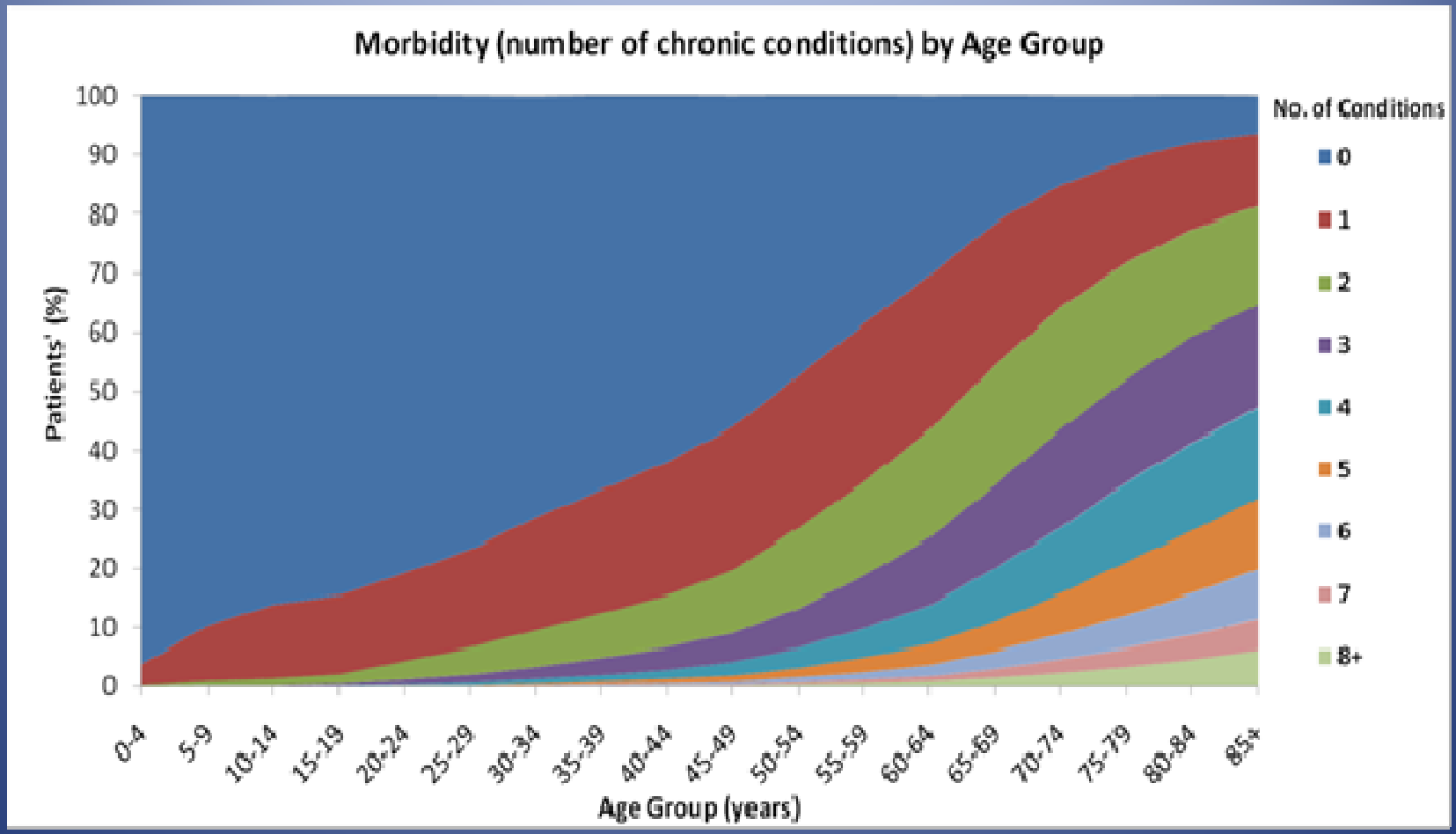
Diabetes up 29% by 2025 to reach 4 million

People living with **dementia** will more than double over the next 30 years to 1.4m

Arthritis up 100% to 17m by **2030**

People living with cancer doubling by 2034 to 4m

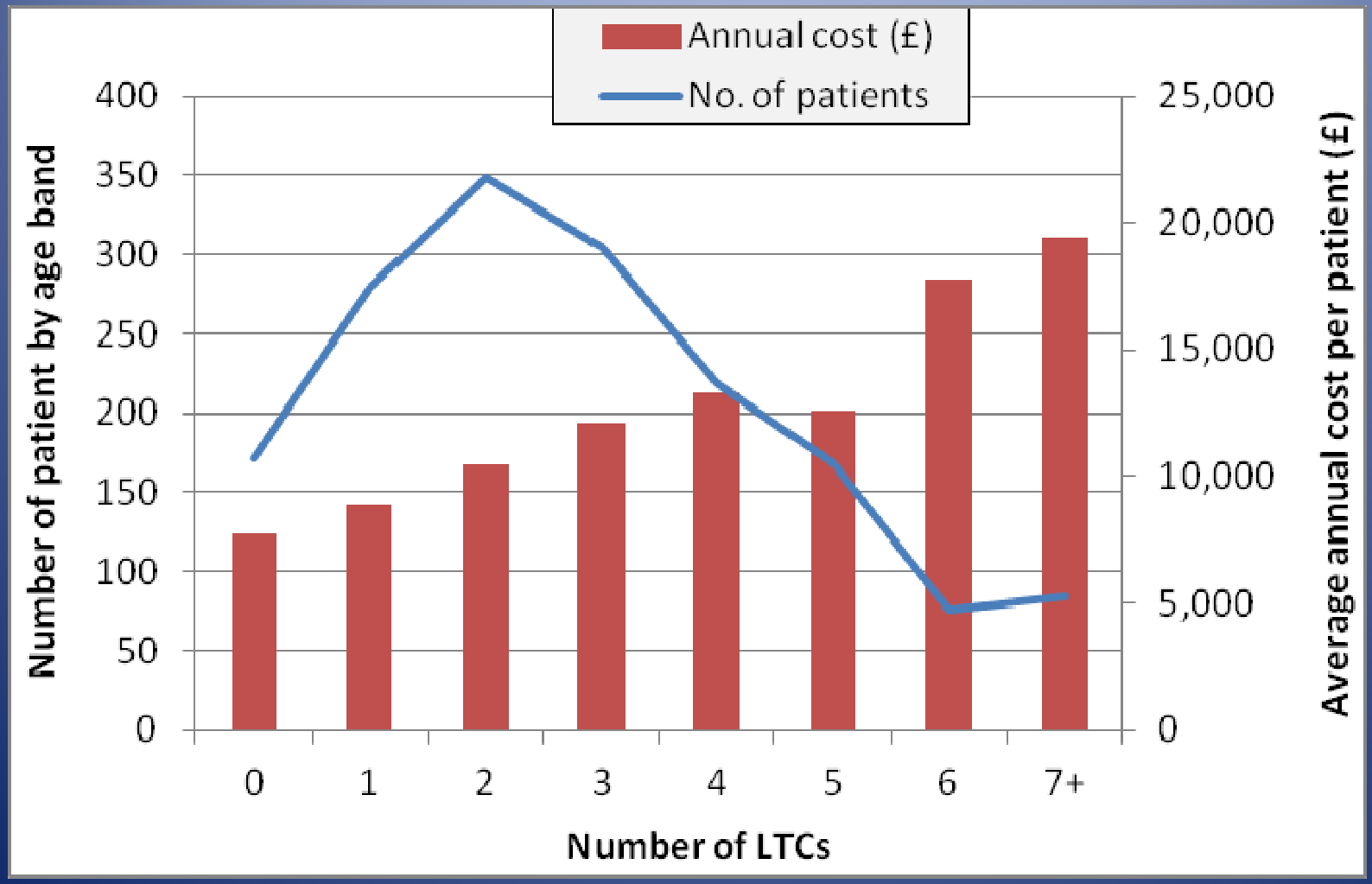
Multimorbidity in Scotland is becoming the norm

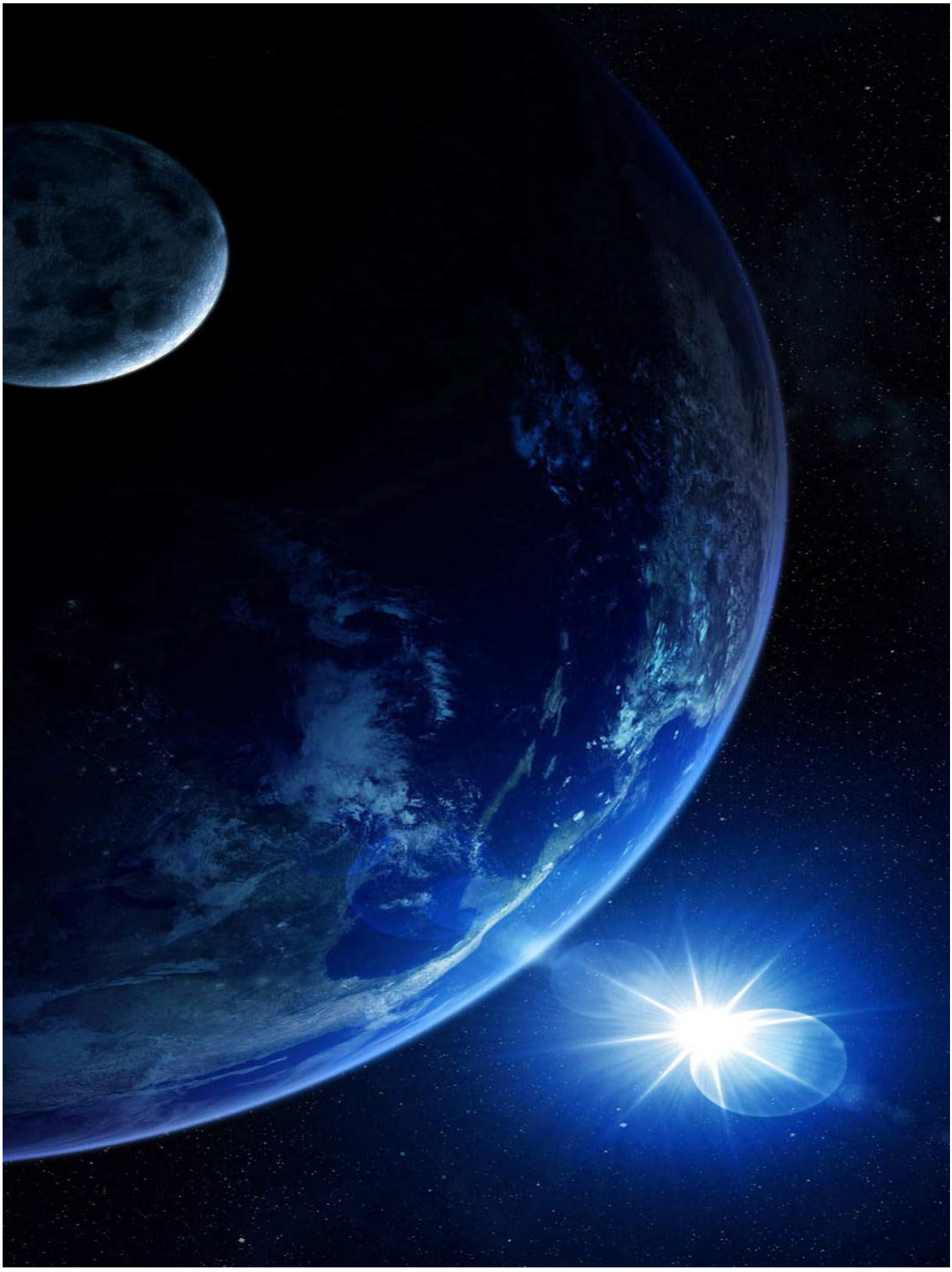


- The majority of over-65s have 2 or more conditions, and the majority of over-75s have 3 or more conditions
- More people have 2 or more conditions than only have 1

Barnett et al (2012)

Relationship between number of long-term conditions and cost



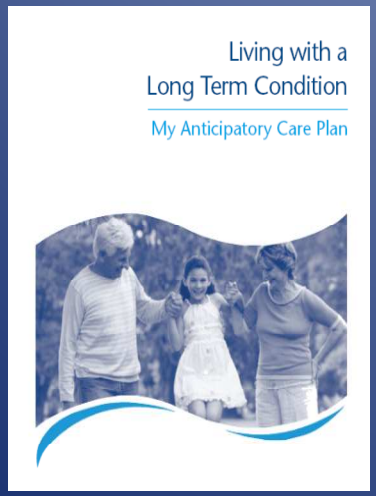


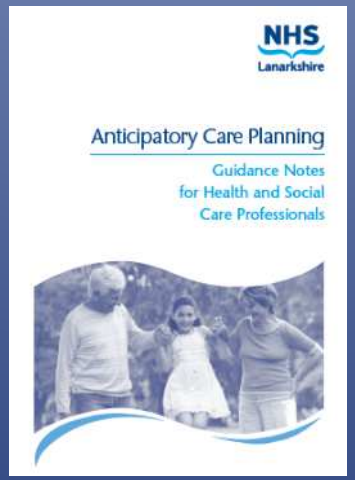
Where we started...

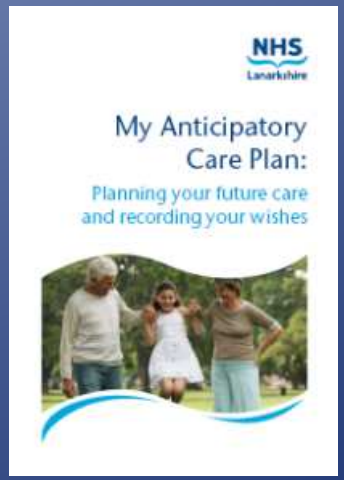
- LTC collaborative: 14 day challenge
- A multi agency expert working group was convened to develop the ACP, guidance notes, patient and carer information, and a teaching package that would support the ongoing and sustainable implementation.
- As inclusive as possible.

Process

- Developed ACP, Guidance Notes, Patient / family information, Implementation pack
- Tested ACP and process: 9 Care Homes
- Wide Consultation







Testing the concept

- 346 ACP completed
- 55 Care home residents died PPC
- 129 residents followed for 6 months
- 37 Residents followed for 5 months
- 33 Residents followed for 4 months

Evaluation

- Person (catch the comments)
- Relatives/Carers
- Care Home Staff
- Qualitative – experience of those involved, benefits and impact on them
- Quantitative – robust data to support and evidence the impact

Impact

- A&E attendance fell
- Emergency inpatient admissions fell 36%
- Length of stay fell 51%

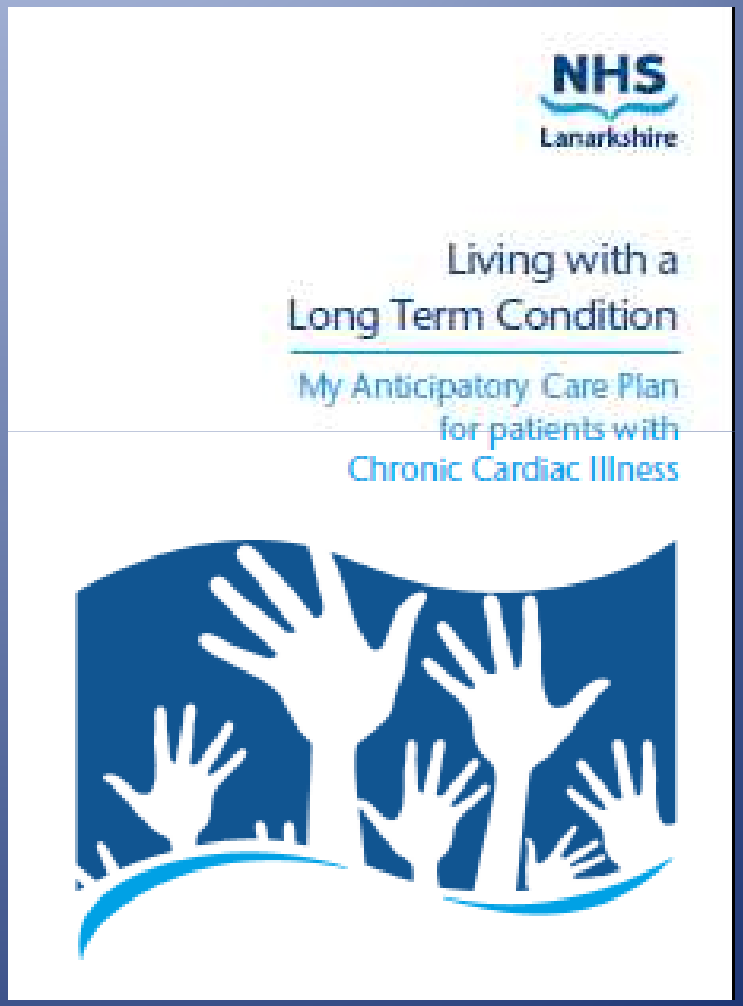
- Residents – positive
- Families – positive
- Staff – positive (need time, uncomfortable in the beginning)

What we did next.....

- Formally launched ACPs
- Implementation pack
- Full communication plan
- Briefing to Board, ADNs, SLC, NLC, Care Commission, GPs
- Briefing to ERC
- Introduce ACP to Integrated Care Management / community Nursing
- Audit template – uptake / reporting
- Sharing electronically
- Requests for condition specific ACPs

Developing condition specific ACP

- Development Group:
  - Ownership
- Patient Involvement
- Advanced Communication skills
- Wide consultation
- Refine, Refine, Refine
- Further consultation
- Agreement & sign off



And then… The Team

- Brains
- Heart
- Courage

Special thanks to Sheila, Margaret, Tony, Claire and Amy

The next phase

- Targeted approach using cascade training & awareness within Care Homes, Community Nursing, Acute Hospitals (HSMR) (including admin teams)
- Identification of ACP champions
- Education for Community Nursing
- Educations session within the Acute Hospital environment – blast sessions. Sessions advertised on intranet
- Monthly reporting from Care Homes, Community Nursing
- LearnPro module for generic ACP

Who we targeted

- Care Home Staff
- Community Nurses
- Acute Hospital Staff & case note review
- Emergency Response Centre: Protocol change
- Social Workers: Homecare
- Patient Advocacy
- Carer Groups
- General Practitioners
- General Public: various events / Groups

- Specialist Nurses
  - COPD
  - Heart Failure
  - Multiple Sclerosis
  - Parkinson's Disease
  - Renal
  - Stroke

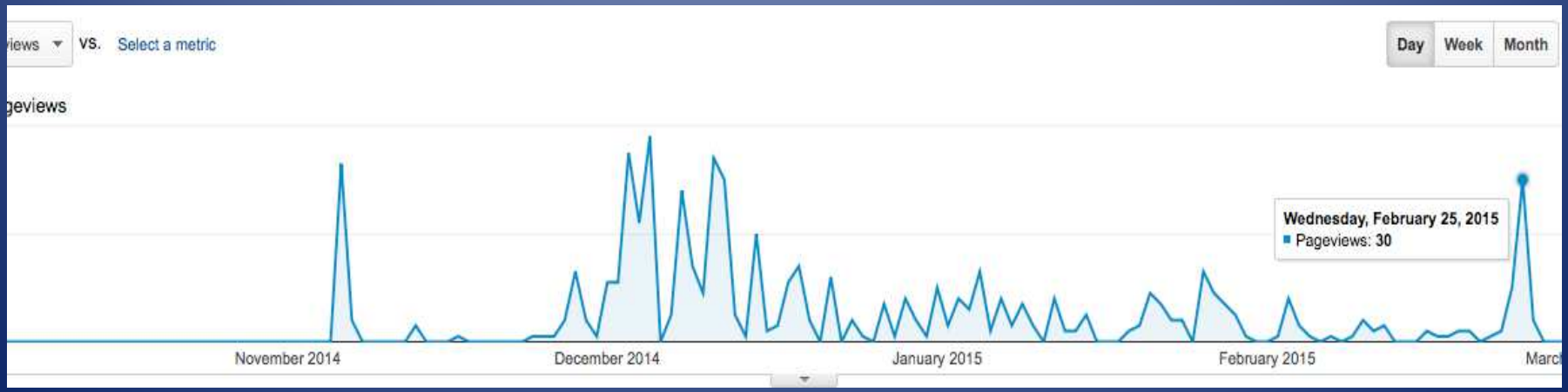
- Public Awareness Campaign

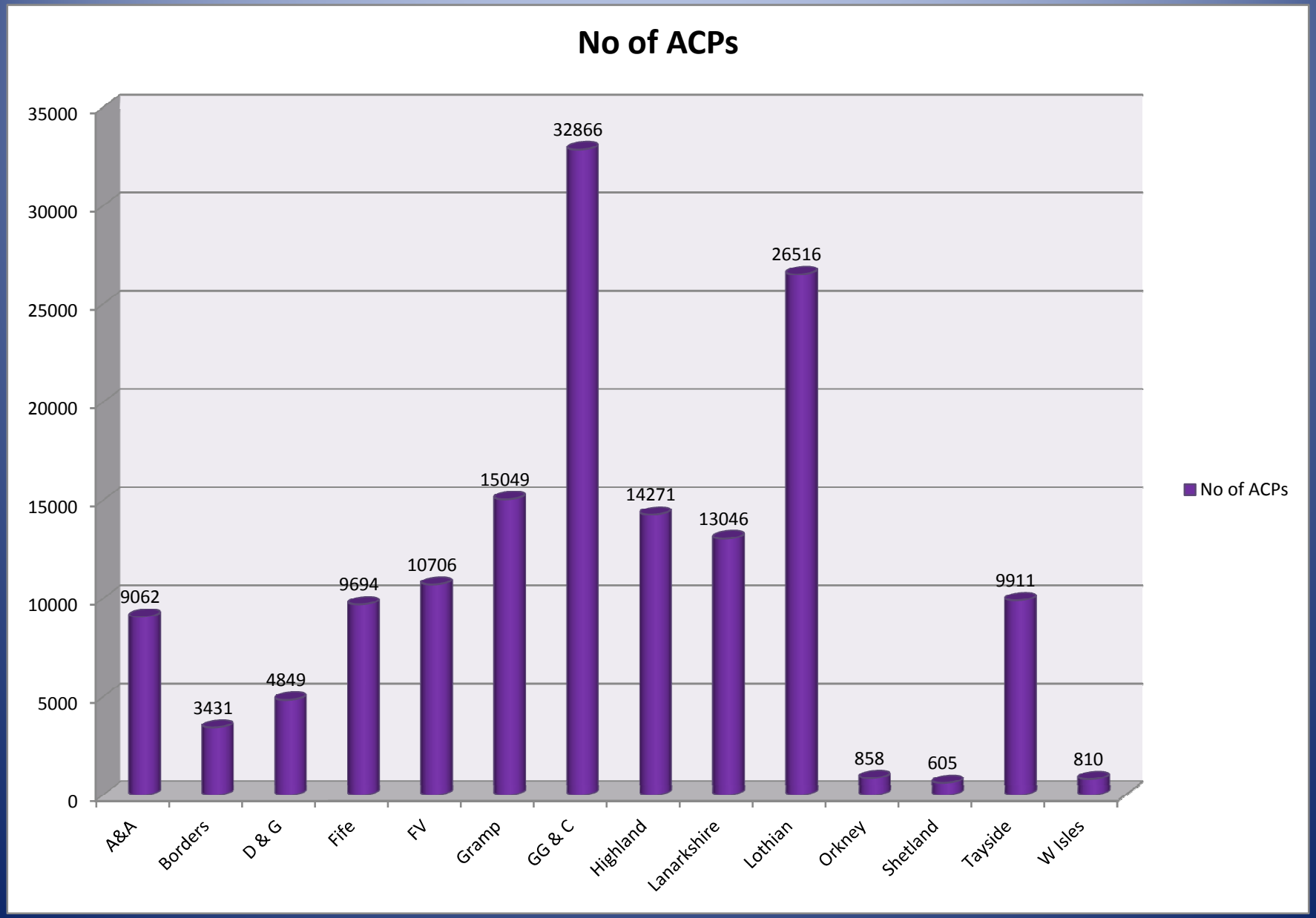
Public Awareness Campaign

- TV adverts on STV & within GP practices
- Poster Campaign
- Lamp posts advertising
- Radio advert for 6 months in Leisure Centres
- Bus advertising

Impact

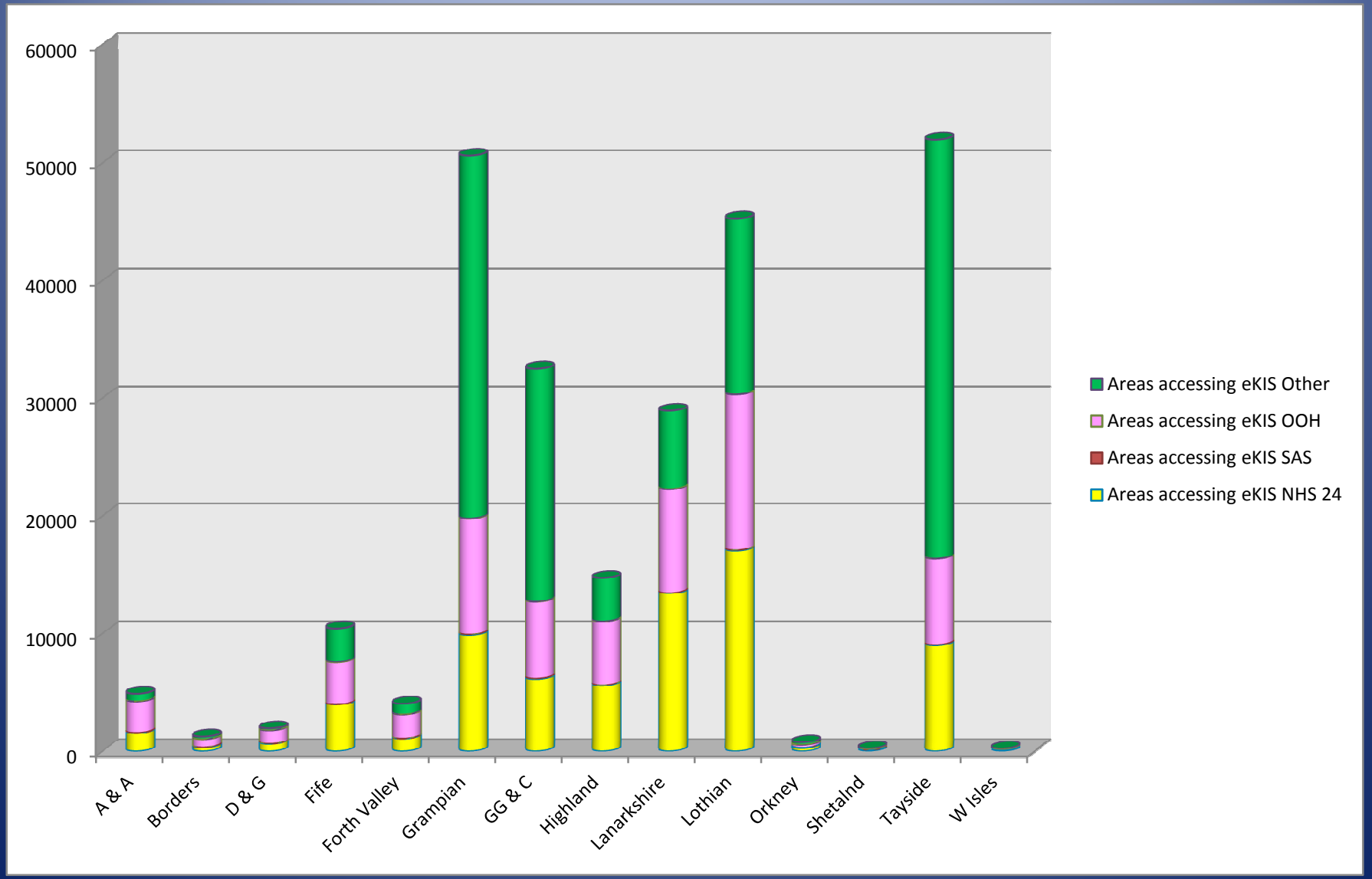
- 34 % increase in POA registrations in Lanarkshire
- 56% of available TV audience
- 25% watched TV advert more than 3 times
- A total of 1.1 million viewers




No of ACPs
35000
30000
25000
20000
15000
10000
5000
0
9062
3431
4849
9694
10706
15049
32866
14271
13046
26516
858
605
9911
810
A&A
Borders
D & G
Fife
FV
Gramp
GG & C
Highland
Lanarkshire
Lothian
Orkney
Shetland
Tayside
W Isles
No of ACPs

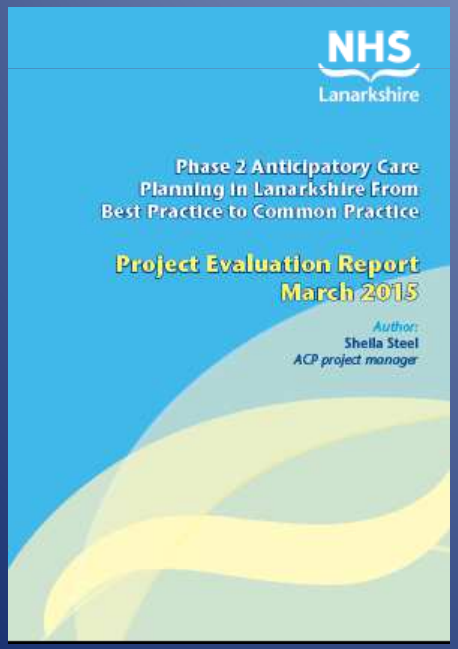
Accesses to eKIS

Specific Access in one month



So what??

From January 14 to March 15: 431 care home residents avoided hospital admission and remained in their preferred place of care:



An ACP is very beneficial to patients, carers and those that are involved in their care

Care Home Manager

Completing an ACP is like a wakeup call ... to take ownership of my own health and inform others with regard to my wishes/choices

Service User/ Patient Advocacy

"I'm pleased to know that my preferences will be considered in the event that I am unable to make decisions for myself. More importantly that my wife and family are aware of my choices for the future and an ACP is an excellent way of capturing these."

Mr William Steel
Age 75

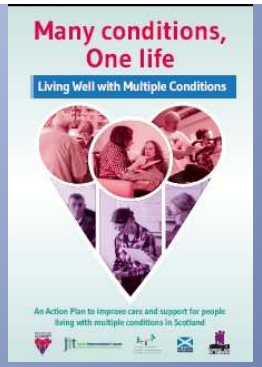
Residents who have completed an ACP with their family, have done so in the knowledge that their wishes are valued and respected

Care Home Staff

Anticipatory Care Planning made me think about my own health and writing down my preferences and wishes gave me a feeling a control. This enabled discussions with my partner with regards to my health needs and the relevant signs and symptoms to lookout for which may indicate a change in my condition

Chris Farrell

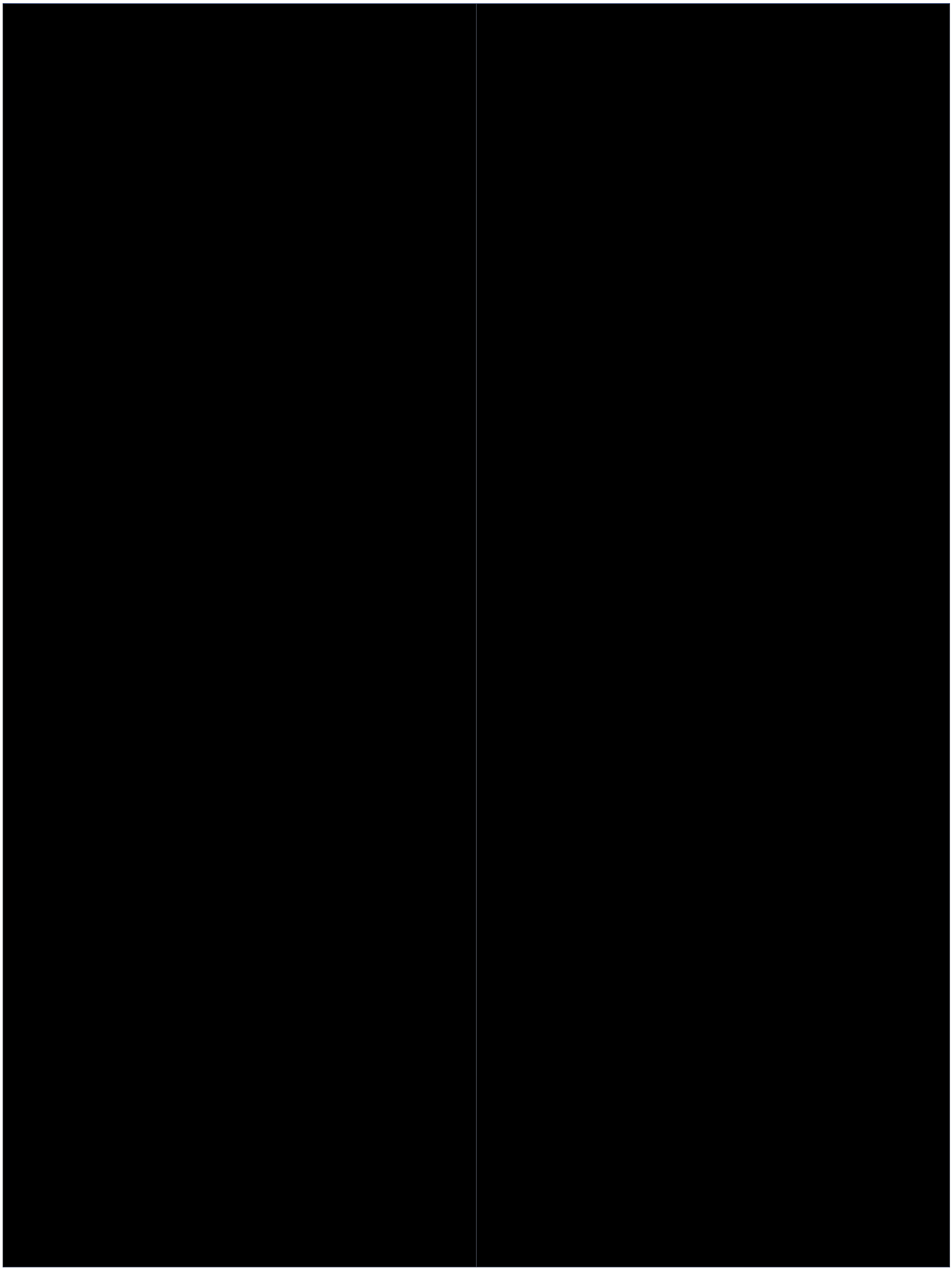
Next Steps.....
Action 3: Primary Drivers



Action 3: Increase the use of Anticipatory Care Planning, Carer support plans and Key Information Summaries. This will mean that people, and those who support and care for them, are better prepared to deal with health problems which may fluctuate or get worse over time.

- Embed Anticipatory Care Planning into Localities especially for those with multiple conditions
- Maximise the potential of the Key Information Summary and improve interface working
- Provide effective carer support and emergency plans
  - Incorporating carer contingency plan into ACP

In summary



Remember……

Thank you

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