Anticipatory Care Planning in Scotland

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Aims - Why focus on Anticipatory Care Planning?

To achieve the 2020 vision requires high quality, person-centred, sustainable healthcare for an ageing population who have an increasing prevalence of long-term conditions and multiple morbidities.

Currently, in Scotland, 80% of individuals admitted to hospital are over 75 years. Of these admissions, 30% could be avoided through mainstreaming an Anticipatory Care Planning (ACP) approach supported by a model providing appropriate case management, interventions close to home, better signposting and access to appropriate services, including supported self-management, local intermediate care, enablement and rehabilitation.

5-6% of the population could potentially benefit from ACP to offer interventions in a timely way to enable informed choice, improved quality of life and ensure optimal outcomes.

ACP triggers based on situation, condition and assessment have been developed to support ACP initiation. Triggers include falls, which account for 10% of unplanned admissions, and focus on complex support needs, long-term conditions, polypharmacy and dementia.

The essence of ACP is to help individuals and carers with long-term conditions to have the confidence, control and choice that comes with knowing what might happen, awareness of small indications of change and being ready to take the right steps with the right support from the right people at the right time.

ACP is a person-centred, proactive, “thinking ahead” approach that should be tailored to the stage of the patient’s condition and, as such, exemplify person-centred values and care provision. The key principles of this approach are to ensure that the person and their carer are placed at the very centre of the decision-making process about their health and social care needs.

Methods and improvement activities

A National Action Plan has been developed by a cross-sector, multi-agency group informed by the Many Conditions, One Life initiative (2014) to “increase the use of ACP, Carer Support Plans and Key Information Summaries.”

Raising the profile of ACP at organisational, professional and public level will require cultural change supported by collaboration through development of effective and extensive networks. Baseline scoping work has been informed by logic modelling focused on identifying local leads and NHS Boards and Partnerships and establishing a national ACP Programme.

Work to inform future spread is ongoing with tests of change using ACP triggers and risk prediction modelling with a range of NHS Boards and Partnerships.

Tests of Change

- Single ACP for Scotland
- Public awareness raising
- Advocacy
- Exploration of barriers
- Risk Predictive Models
- Role of Allied Health Professionals in ACPs

Impact measures include:

- Number of ACPs (see Figure 1) and Key Information Summaries (KIS)
- Admission Readmission reduction
- Reduced length of stay
- Reduction in delayed discharges
- Improved patient experience
- Improved quality of life

Outcomes

- Workforce and system engagement with KIS is increasingly positive
- 4.6% of the Scottish population now have a KIS
- Recent research (NHS Lothian) has shown that hospital admission is greatly reduced if the individual has a KIS
- Healthcare Improvement Scotland’s ACP team working in partnership with Carers Bill representatives
- Cross-sector workshops to promote further engagement and cultural change
- Develop self-management App
- Working with partners to scope information gathering requirements for ACP and development of KIS

References: