Anticipatory Care Planning as Core Business- The Story So Far…

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Situation:

Recent work within NHS Lothian reinforces the need for effective Anticipatory Care Planning (AnCP) for patients at risk of deterioration and dying. Local data identifies AnCP as relevant for >80% of patients at risk across hospital specialities, with 51% in baseline cohort dying within 12 months of the index admission. AnCP is then core business for healthcare professionals and requires a 'joined up' approach across care settings.

Background:

The Scottish Patient Safety (SPSP) Acute Adult programme aims for health boards include a 50% reduction in cardiac arrests and a Structured Response to Deterioration for 95% of patients[1]. In Lothian a breakthrough series collaborative is underway to deliver these aims, utilising a Deteriorating Patient Change Package to support the early recognition and management of deterioration. We are integrating AnCP within this work stream; investigating and developing reliable processes that support the safe, effective and person-centred care of people with a background of progressively declining health who are at risk of deterioration and dying. This improvement work is being taken forward by frontline clinical teams, working collaboratively with quality improvement and specialist palliative care, information technology teams, patients and carers, educators.

Assessment:

The Information Reconciliation model (Figure 1) provides a framework for development towards achieving whole system improvements. This model places communication with patients and those important to them at the centre of care processes to achieve shared understanding of goals and priorities. Clear documentation of a care plan & sharing of information across settings is emphasised, with key opportunities for sensitive discussions & review of care priorities and plans highlighted. The Key Information Summary (KIS) can steward this information between different settings and professionals; currently >35,000 KIS in Lothian for patients with complex needs.

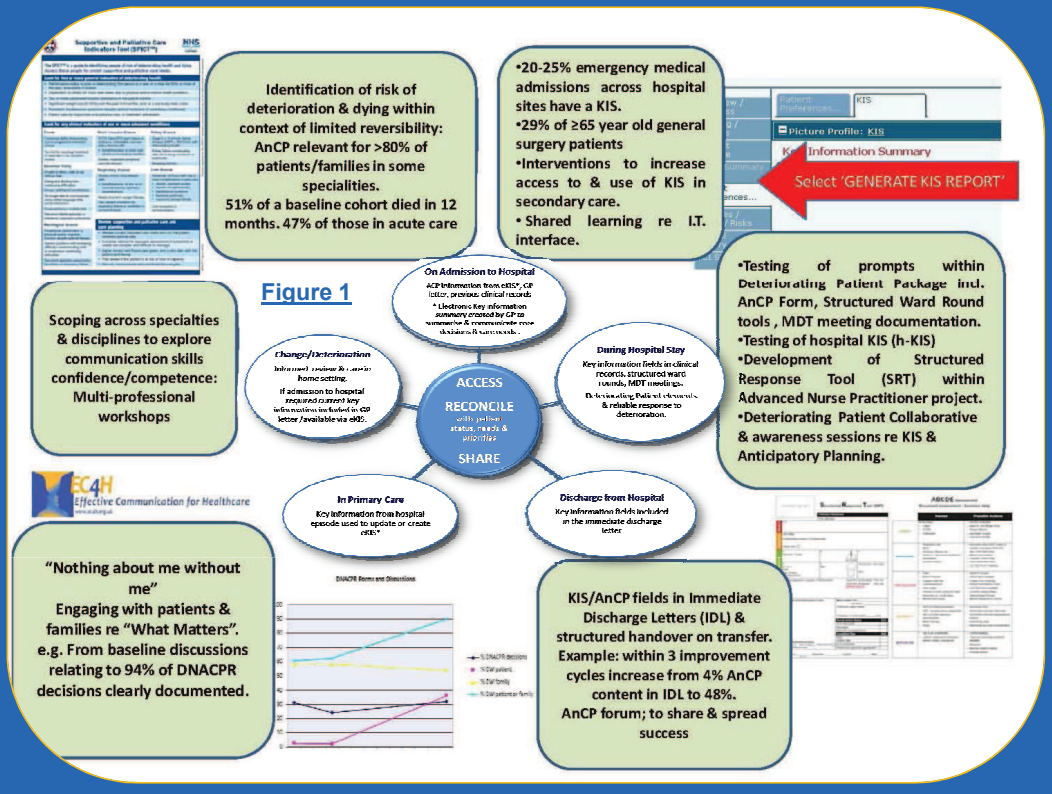
Recommendation

An AnCP/ Information Reconciliation forum has been established within the Deteriorating Patient Collaborative, bringing together key stakeholders undertaking related quality improvement initiatives within a range of specialties and across hospital and community settings. Aims: to share learning, provide support, discuss barriers and opportunities and importantly, optimise use of time for busy clinicians and the impact on care outcomes for patients and families. The forum has face to face meetings with group email communication. An online community is under development.

Response:

AnCP Forum membership

- Acute admissions
- Acute medicine
- General Surgery
- Advanced condition specialists
- MOE/Stroke
- Oncology
- Vascular
- Respiratory
- Hospital at Night
- Frailty teams
- GP leads
- Care home liaison
- Access Practice
- Quality Improvement
- Education team
- Palliative care
- Information technology



Key outputs from forum to date:

- Confirmed the need for and benefits of a whole systems approach
- Raised awareness & dialogue regarding AnCP within general services
- Scoping: clinicians education needs re AnCP & improvement methods
- Clarification and consistency re use of key AnCP terminology
- Exploration of outcome measurement
- Collaborative working across teams to reduce overall workload
- Sharing success & considering spread in context
- Data / improvements relevant to other standards eg Older People in Acute Care
- Exploring key contribution of all team members to AnCP e.g. Speech & Language Therapists, Occupational Therapists
- Proof of concept, including the feasibility and acceptability of AnCP / information rec for patients, families, professionals.

Next steps:

- Development of an online community
- Continue to expand membership to steer AnCP related local improvement & capture early, evolving progress.
- Further exploration of outcome measurement including how data sources can be triangulated to measure impact.
- Refine glossary of key terms including always events and avoidable harm in context of person-centred anticipatory care.

1 http://www.scottishpatientsafetyprogramme.scot.nhs.uk/programmes/acute-adult

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