Living Well in Communities

Anticipatory Care Planning in the Real World

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Let’s Think Ahead
Anticipatory Care Planning in the Real World

- Three Letter Thursday
- ACP Matters
- ACP - The story so far......
- Making it happen in the real world (table discussion)
- Ten word commitments
Let’s think ahead

The Challenge of Change

“Some people want it to happen, some wish it would happen, others make it happen.” — Michael Jordan

Let’s have the right conversations at the right time

“ACP Matters”
How we got here

- Improvement Collaboratives
- ACP Task and Finish Group
- Living Well in Communities
- National Action Plan for ACP
- ACP Programme Board and Delivery
National Action Plan for ACP: Primary Drivers

1. **Raise awareness** and profile of ACP and embed principles within each locality to help those with multiple morbidities

2. **Share Information**
   - Supporting people to develop their plan
   - Design ACP material for individuals
   - Focus on early intervention

   Supporting professionals to work together
   Increase access to the Key Information Summary (KIS)

3. Work to ensure **carer support** aligned with ACP

Ensure delivery of ACP for all who would benefit
Making the links

Palliative Care Strategic Framework

National ACP Action Plan

Identifying those who will benefit

Co-ordination of care

Education and training

Align with integration contract and service reviews

Improving understanding and health literacy

Having the right conversations

E-Health to support the right info sharing
What do we need to do in the real world?

"Thinking ahead"

Working with people and those close to them ..... to set and achieve common goals in an ongoing process ...

Person-centred care and ownership

Improving quality and consistency

The right conversations

To ensure ....the right thing is being done at the right time by the right person(s) with the right outcome
Person-centred care with personal ownership

Let's think ahead

My Anticipatory Care Plan

End of Life Care
Think Ahead Think ACP
ACP Triggers-
Condition Situation and Assessment

- Elderly and living alone, housebound
- Infants, children and young people with complex and palliative care needs
- Complex support needs
- Unscheduled care access
- Carer stress
- Condition(s) specific (disease registers)
- Risk predictive tools
- Collaborative assessment
Children with complex needs

Identifying who will benefit
Recognising opportunities—
the Chronic Illness Trajectory

(Aadapted from McCorkle & Pasacreta 2001)
The value of a KIS

67 year old with metastatic bowel Cancer (likely pulmonary and now also skin mets and extensive local nodal disease); background hx of recurrent PTE: (on lifelong anticoagulation with s.c. LMWH); Hickman line in situ for expected palliative chemotherapy, however little response to this. Recently more confused but no headaches and possibly oversedated; MST reduced from 100 to 90mg bid; and recently commenced on syringe driver. Marked deterioration??: cerebral metastases. Supportive care only. Detailed discussion, well informed and aware prefers end of life care at home; wife very switched on and caring. DNA+CPR form in place.
Current % of ACPs per population

8.17%
3.76%
4.22%
5.06%
3.69%
3.31%
6.88%
5.37%
3.85%
4.31%
4.94%
4.32%
5.52%
3.31%
4.17%
3.69%
5.06%
Having a KIS significantly reduces chance of hospital admission.

In Scotland we have 11% reduction in the hospital admission for the over 75s.
Thinking ahead
Time to bring jigsaw together.........
Along with evidence....and...

a bit of blue sky thinking and a leap of faith

Some scoping..... testing the water....and.....
.....spreading the word!

It can catch on!!!
The need to show impact and improvement: Proposed change measures:

• Number of ACPs and KISs
• Number of Power of Attorneys
• Admission/readmission rates
• Bed days and delayed discharge
• Percentage of last 6 months of life spent in hospital

• Workforce engagement
• Patient and carer/family experience

Measure change through Contribution Analysis
ACP challenges...feedback from the real world

• Time- preparation, planning, doing it right
• Lack of awareness at all levels
• Avoiding difficult conversations
• Lack of certainty
• Loss of control
• Everyone is different
• Forms and legal issues
• Co-ordination and navigation
Additional focus needed......

• Raise profile and enable cultural change

• Learning and communication strategy

• Identify individuals who would benefit from ACP

• Agreed supporting documentation and supportive technology
Anticipatory Care Planning (ACP)
Commitment Card

Name: Paul Gray
Organisation: NHIS Scotland

Please use the space below to tell us your commitments to ACP:

I want to ensure that everyone involved in care understands the value of ACPs and is equipped to have the right conversations about this.
KEEP CALM AND WE CAN MAKE IT HAPPEN