NHS
University Hospitals of Morecambe Bay
NHS Foundation Trust

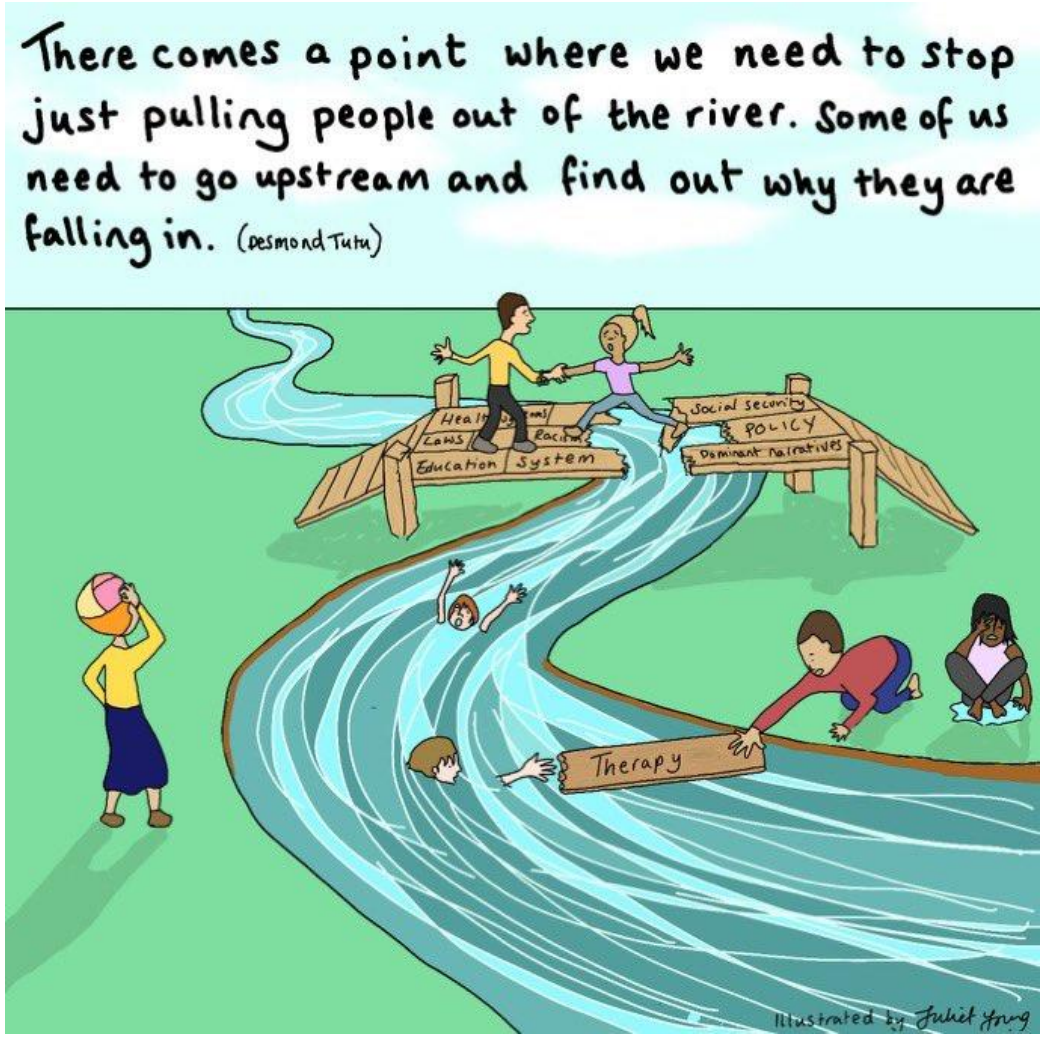
Anticipatory care planning- the Morecambe bay experience

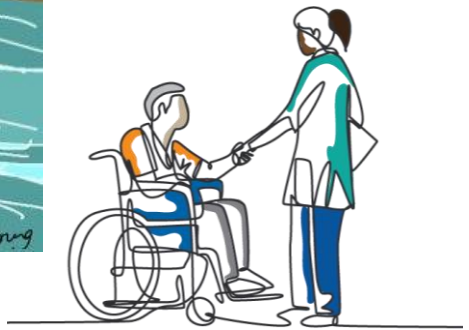
"Creating a great place to work and a great place to be cared for"

Background

- Morecambe Bay - large and dispersed geographical area
  - 35 member GP practices; 8 PCNs
  - Population of circa 360,784 patients, a range of both urban and rural communities.
  - Covers part of north Lancashire, south Cumbria and a small area of North Yorkshire County Council
  - Large discrepancies between areas of deprivation and affluence
  - Pockets of ‘super-ageing’ populations

- Vanguard journey:
  - Risk stratification – eFI tool (admission avoidance)
  - Moved to softer criteria - lower levels of frailty and all age
  - Commissioning intention of better up-stream management - improved patient activation and self care


There comes a point where we need to stop just pulling people out of the river. Some of us need to go upstream and find out why they are falling in. (Desmond Tutu)
Social security
POLICY
Dominant narratives
Education System
Therapy
Illustrated by Juliet Young



Our Anticipatory Care Plan - William

- Comprehensive multi-faceted assessment
  - Advanced decisions, carer info (and pets), demographic and social, functional ability, anticipatory care, dementia and baseline physical exam (NEWS2)
- Part of Care Plan landscape
  - Fixed end point – e.g. post-surgery, post discharge, wound management and End of Life
  - Long Term Condition - living well e.g. Diabetes, Asthma or Hypertension
  - Anticipatory Care Planning –living and dying well with frailty
- Data entry template in the Primary Care ePR (**EMIS Web**)
  - SNOMED code term (404) and free text associated –context/soft issues
- Physical document (inc. Clinical summary) generated for patient

Implementing Care Plans - Workforce - Emma

- Care Navigator (Advanced Practitioner or Nursing Associate, Band 4)

LPA, Carer details/needs & Carer contingency plan, Emergency contact, Services involved (NHS/other), Demographics, Information about property, Safeguarding concerns, Details of recent hospital admissions, Disability, Mobility, Discussion around falls, Care needs/assistance, Ownership of home, Communication, Vision, Hearing, Nutrition, Continence problems, Sleep, Memory problems, Medication - asking if struggling, Goals - what is important to you/what do you want to achieve, Observations (BP, pulse, temp).

- Care Coordinator (Registered Nurse or AHP, Band 5)

As Care Navigator, plus: Guide for future care and emergency decisions, Preferred priorities of care, CPR discussed with patient, Chest pain / infections, UTI, breathlessness, falls, admission to hospital due to exacerbation of condition(s), Emotional/mental health needs, Breathing, Frailty score, Advice given to patient if they become unwell, Skin, Pain.

- Case Manager (Band 6 / 7 / 8a), GP, ANP, Specialist Nurses.

As Care Coordinator, plus: Advanced statement, ADRT, Palliative care drugs, Rescue drugs, DOLS in place, Donor status, Consciousness.

Implementing Care Plans- Emma

- Patient identification
  - Referrals from Primary and Secondary Care, Community Nursing and Therapy teams, Self-referral, discharge from hospital, MDTs, Fire Service, Supported Housing & more!

- Expectations
  - Patient has paper copy in own home, and copy uploaded on EMIS.
  - Patients to contact team if any details change.
  - Want to ensure that care plan can be updated by others supporting patients in the future or if health needs change.
  - To be kept in a clear and visible location in case required by emergency services.

Implementing Care Plans- Emma

GP referral to Case Management Team

"MND diagnosis.
Increasingly frail, frequent falls.
Elderly husband is carer, but
now struggling.
Needs extra support".

- Mrs Smith*, 82 years old *pseudonymised
- Lives at home with husband

Medical History

- Motor Neurone Disease (MND)
- Progressive muscular atrophy
- Hypertensive disease
- Macular degeneration

Implementing Care Plans- Emma

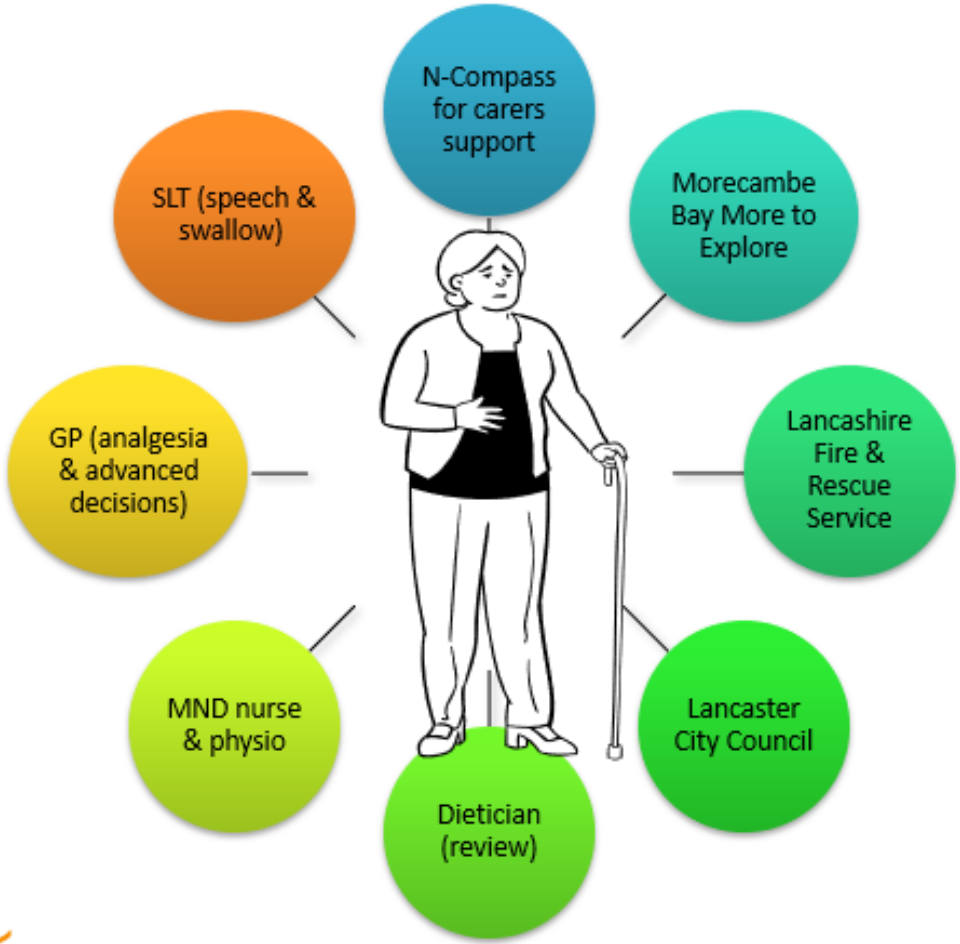
Issues highlighted

Following discussion with patient and family

Mobility & increasing falls	Carer fatigue	Personal care	Major adaptations
Communication	Saliva / Swallowing	Ability to summon help	Sleep
Pain	Nutrition	Scam / nuisance calls	Fire safety

Already had a lot of 'health' input when the team first became involved.

Implementing Care Plans- Emma



Actions following completion of care plan – signposting & referrals.

Implementing Care Plans- Emma

KEY THEMES

- Patient led – listening to patient wishes & 'doing with' not 'doing to'.
- Respecting patient decisions.
- Supporting not only patient, but carer and key family members.
- Highlighting risks / benefits.
- Managing expectations.
- MDT working & effective communication.
- Avoiding unnecessary admission to hospital.

Positive Feedback

"...has now agreed to having care which [care coordinator] is kindly progressing including things like telecare, benefits etc. Thanks." (MND OT)

"I see that you continue with your input and timely referrals as a result, thank you." (DN)

"I am grateful that you ask our MND patients about these factors as they can be very significant" (MND Physiotherapist)

"Good to talk to you and thank you for all your work and care over this." (Daughter)

"Thank you for all this information. Thanks so much for your time and patience!" (Daughter)

"I am so grateful that you have made contact with me" (Patient)

The technical bit - William

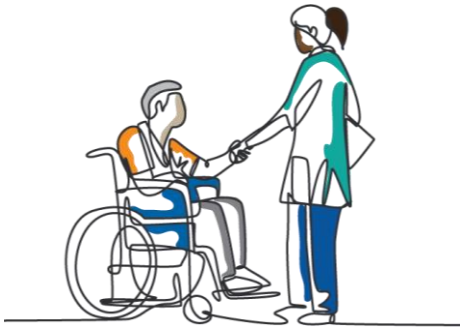
- Write into the Primary Care ePR (EMIS Web) and read many times
- Real time electronic record sharing (can copy/retain) (**Healthcare Gateway-MIG**)
  - Adult Physical Community Services
  - Acute Hospital (ED/AMU/Wards/Outpatients etc.)
  - Primary Care Out of Hours
  - Adult Social Services
  - Hospices x2
  - Mental Health Service
  - Limited linkage to ICS shared care record
  - 999 service (painful) 5 years, 3rd digital platform at their end and still not live
- Electronic sharing provides digital overwrite
- Starting to triangulate shared record view with hospital admissions
- Next steps- whole system (inc. patient) read/write (costly)

Immediate impact population health- William

- Having the structured conversation often socialises/simplifies difficult concepts and leads (from personal experience) to a more informed/engaged patient and/or advocate i.e. there is a direct health benefit from the process.

- A high-quality ACP assists clinical colleagues working in our EDs assess suitability for acute hospital admission and effectively/safely “turn around” at the front door.

- The ACP is a key reference document for any inpatient stay and forms part of an efficient discharge process.



Immediate impact population health- William

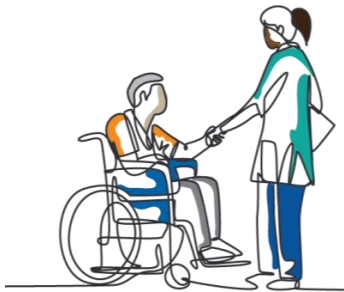
The ACP:

• Clarifies the patient's wishes, informs their relatives/carers and empowers decision making in the home, helping to clarify carer aspirations.

• Will identify unmet clinical, social care and voluntary sector needs and stimulate pro-active referrals to appropriate services.

• Will inform health escalation decisions within the regulated care sector (e.g., control the issue of providers using 999 services as first aid provision).

• Would inform clinical decision making on Ambulance Service decisions to transport, on regular and out of hours Primary Care determinations to admit and the efficiency of our Frailty Co-ordination Hub.



Challenges and Further work - Helen

- Widening use of care plans across all pathways
  - Engagement with other users to understand barriers and opportunity for improvement
  - Deciding which clinical system to use & interoperability
- Regular review of content and standard
  - Keeping them up to date is critical – by who? And when?
  - Ensuring quality of the care plan
- Time to do them
  - A meaningful care plan can only be generated on the basis of a good conversation / assessment
  - You may discover that there are interventions that are necessary
  - Capacity in providers who will receive onward referrals especially VCFS
  - Do we have robust operational plans for when additional care and support is inevitable?

Any questions or feedback?

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