New topic referral exploratory work

Anticipatory care

What is anticipatory care?
People use it as a general term eg a paper investigating the contribution of community nurses to anticipatory care defined it as 'proactive care, which is oriented towards prevention of adverse events'
From a HealthScotland document: ‘There is no single definition of anticipatory care; however a working definition based on broadly agreed principles is about activities or programmes of action to prevent and mitigate ill health-identifying and engaging with people at risk of ill health, identifying and prioritising individual health needs, offering appropriate services and support, and providing monitoring and follow-up.’
From topic referral form: ‘One or more preventive interventions delivered to individuals, with the overall aim of shifting the focus of service provision from reactive to preventive care, adopting a whole population perspective across all aspects of service planning and delivery’. It is an umbrella term for a number of discrete interventions...

What is anticipatory care planning?
A term mostly used in end of life care (incorporates writing of wills)

Anticipatory care planning: thinking ahead philosophy. More commonly applied to support those living with a long term condition to plan for an expected change in health or social status. Includes health improvement and staying well.

It’s a dynamic record developed over time. It’s a record of preferred actions, interventions and responses that care providers make following a clinical deterioration in the person’s care/support (eg concerns/goals, wishes for end of life care).

There’s no blueprint for it but should generally address the following: What if your carer becomes unwell?/ What to do if condition worsens/ What would you like to do if you become acutely unwell with...?/Preferred place of care = home, community hospital, care home, acute hospital?

What is literature like?
No secondary studies

Mainly evaluations of Keep Well.

Mainly government documents.

Mainly evaluations –qualitative studies/descriptive statistics

Scottish Government documents - Ref 1: Guidance on anticipatory care planning for local teams
Audits - Ref 42: Medical anticipatory care plans (MACP) in advanced heart failure (HF)
Type of study: abstract of audit in large Scottish city. 100 patients with advanced HF with MACPs

Outcome: fewer hospital admissions and higher percentage of people dying where they choose in those with MACPs. No statistics.

Qualitative studies - Ref 17: Keep Well – anticipatory care in primary care. Paper on the tensions underpinning a programme such as Keep Well which tries to integrate population-level health improvement with general practice-based individual care. 74 people interviews over 3 years giving 118 interviews.

Interviews with stakeholders at strategic and operational levels of Keep Well.

Ref 41: Proactive cancer care- Development and evaluation of an ongoing cancer review document.

What are the big initiatives?

Keep Well: Scottish Government initiative (2006-) – national programme of anticipatory care targeting those at risk of cardiovascular disease (ages 45-64 years) in deprived areas. People were invited to attend health check (usually done by practice nurse). Interventions and services then offered as appropriate. Interventions could be medical (eg statins), behavioural (eg smoking cessation) or social (eg literacy support). Monitoring and follow up is provided.

Ref 63: Keep Well website
Ref 78: Qualitative study on staff views of Keep Well
Ref 16: Qualitative study on the role of the outreach worker in the Keep Well programme
Ref 65: Impact evaluation of Keep Well
Ref 17: Keep Well- described above
Ref 53:Pilot evaluation of Keep Well (Rural)
Ref 54:Evaluation of anticipatory care pharmacy programme (Keep Well)
Ref :Have a Heart Paisley – Scottish demonstration project (2001-2008). 11277 people aged 45-60 were offered CV and general health risk assessment with referral to health improvement programmes for smoking, diet and exercise, with support from dedicated health coaches.

Ref 57: The aim of this report was to develop a series of four case studies from selected examples of existing practice of community and voluntary sector organisations working in partnership with Keep Well initiatives to generate and disseminate learning points for other partnerships.

Ref 56: NHS Fife report on Keep Well project. To develop partnership working with community and voluntary sector organisations to enhance delivery of the Keep Well service for homeless clients.
Ref 52: NHS report on what has been learnt from the anticipatory care community pharmacy programme which supports Keep (Patients’ perceptions of Community Pharmacy venues (NHS Lanarkshire); A pilot offering health checks to substance misusers (NHS Lanarkshire); and Patient and staff perspectives of the delivery of a pharmacy scheme and staff views of training (NHS Fife Keep Well).)

- Living and Dying well: A national action plan for palliative and end of life care in Scotland (2008)- Living and Dying Well uses the concepts of planning and delivery of care, and of communication and information sharing as a framework to support a person centred approach to delivering consistent palliative and end of life care in Scotland.

Ref 6: Scottish Government document. Progress report on Living and Dying Well (2011). Boards were asked what they have been doing towards Living and Dying Well.

- Caring together: (Ref 3) A programme to help patients with heart failure cope with symptoms and improve quality of life (NHS GGC, British heart foundation, Marie Curie). Works with health professionals with different areas of expertise.

Shifting the Balance of Care: (Ref 7) Broad NHS/Scottish Government policy.

‘By Shifting the Balance of Care (SBC) we aim to improve the health and wellbeing of the people of Scotland by increasing our emphasis on health improvement and anticipatory care, providing more continuous care and more support closer to home. This requires a partnership approach between the NHS, Local Authorities and the third sector.’

- Long term conditions collaborative - Ref 5: Long Term Conditions Collaborative Improving Complex Care. Scottish Government document on: Ten approaches to help you deliver better outcomes and an enhanced experience of care for older people and for people living with long term conditions (includes ACP).

- The house of care (think this is much broader idea than we’d be interested in so not sure of the relevance but thought I’d flag it up anyway)

The King’s Fund has produced a paper on the house of care. The house of care is a metaphor for a proactive co-ordinated system of care and support for people with long-term conditions.

‘Personalised care planning is at the centre of the house, the fulcrum of a co-ordinated delivery system. People with long-term conditions are encouraged to play an active part in determining their own care and support needs. In pre-arranged appointments they engage in a collaborative care planning process – identifying priorities, discussing care and support options, agreeing goals they can achieve themselves, and co-producing a single holistic care plan with their care co-ordinator (usually a GP or nurse), regardless of how many long-term conditions they have.... Some 3,000 practitioners in 26 communities have begun to introduce aspects of the house of care model via the Year of Care programme.’

The underpinning philosophy of care planning in the Year of Care (YOC) approach states: people with LTCs are in charge of their own lives and self-management of their condition/s, and are the primary decision makers about the actions they take in relation to their diabetes management

people are much more likely to undertake action in relation to the decision they make themselves than decisions that are made for them.
This means the health care professional has a new role. Instead of doing things ‘to’ and ‘for’ patients, care planning is about doing things ‘with’ people, enabling them to identify their own information needs, goals and action plans and supporting them to be good problem solvers as they live day by day with their LTCs. This often requires health care professionals to learn new skills as well as new ways of working.


**Smaller initiatives:**

Ref 70: MET office weather warnings for patients with COPD

Ref 25: It has been hypothesised that COPD exacerbations and admissions can be reduced by predicting periods of cold weather coupled with patients’ alerts and education. Healthy Outlook service provided by the Meteorological Office, UK, was used in patients with mild-to-moderate COPD. This anticipatory care model was not associated with reduction in admissions from COPD exacerbations.

Ref 15: Community based anticipatory care service for patients with COPD (2012). Qualitative study on stakeholders involved in delivering the initiative. Qualitative methods to explore views on CBACS. N=64. Explored stakeholder views of the utility and design of a community based anticipatory care service. Focus groups and in-depth interviews.

Ref 43: Pharmacist led intervention to check for cvd and diabetes in a South Asian population

812 South Asian people without CVD or diabetes, aged 35-64 years attended a pharmacist-led health check (including Blood Pressure, Body Mass Index and venepuncture) in their general practice. An action plan was agreed between pharmacist and patient including onward referral. Pharmacists and GPs worked collaboratively to follow up clinical results falling out with accepted ranges. People with raised CVD risk were referred to their GP for statin initiation. Referrals to health improvement services were made on the basis of modifiable risk factors for CVD: 178 (21.9%) to exercise programs, 21 (2.6%) healthy eating, 33 (4.1%) weight management, 37 (4.6%) smoking cessation, 22 (2.7%) literacy, 13 (1.6%) money advice and 8 (1.0%) to employment services.

Anticipatory care plans - Ref 2: A cohort study of a service intervention in a general practice and a primary care team in Scotland to ascertain whether applying an ACP can help to reduce hospital admission rates in older patients who were at risk of admission to hospital. Cohorts were selected using the Nairn Case Finder, which matched patients in two practices for age, sex, multiple morbidity indexes, and secondary care outpatient and inpatient activity; 96 patients in each practice were studied for admission rate, occupied bed days and survival. Survivors from the ACP cohort (n = 80) had 510 fewer days in hospital than in the 12 months pre-intervention: a significant reduction of 52.0% (P = 0.020). There were 37 fewer admissions of the survivors from that cohort post-intervention than in the preceding 12 months, with a significant reduction of 42.5% (P = 0.002). Mortality rates in the two cohorts were similar, but the number of patients who died in hospital and the hospital bed days used in the last 3 months of life were significantly lower for the decedents with an ACP than for the controls who had died (P = 0.007 and P = 0.045 respectively).

Ref 73: Anticipatory care planning in care homes reduces hospital admissions at the end of life– Meeting abstract 2012
Questions SHTG when considering a technology

The topic referral form seeks to capture information to answer the following screening questions. The answer must be yes to at least one of the following questions:

1. Is a clear additional health benefit to patients or benefit to the NHS anticipated or evident from the use of this technology?
   Yes. Evaluations show improved health following Anticipatory care plans/interventions. Small number of studies of low quality.

2. Is there uncertainty about the clinical or cost-effectiveness of the technology?
   Hard to answer, as I’m not sure what the ‘technology’ is!

3. Is there wide variation in provision or outcome of the technology across Scotland?

4. Is the technology likely to have a major impact on NHS resources (consuming or releasing)?

In addition the answer must be yes to all of the following questions:

1. Is the technology likely to have a major impact on NHSScotland?
   From what I can see, the idea of ACP/AC seems to be well established. For example, many boards creating ACPs in homes for the elderly, Keep Well, Living and Dying Well.

2. Is there potential for quality improvement from undertaking an assessment of this technology at this time?

3. Is it likely that one or more focussed technology assessment questions can be prepared?

4. Are there likely to be sufficient published research findings available upon which to base a technology assessment?
   There is a fair amount of qualitative evaluations of Keep Well, but little else.

5. The technology should have a CE mark or appropriate regulatory approval or except to have this by the time the SHTG evidence review is complete.

Questions for topic referrer

1. I’m unsure what the topic referrer is interested in. Anticipatory care interventions are mentioned (discrete interventions) – which could cover many interventions eg Keep Well health checks, case management, sight tests for diabetes. However, anticipatory care planning is also mentioned; a dynamic record of a patients thoughts on their future care should there be change in their condition

2. Topic referral form asks about a comparison of effectiveness between anticipatory care plans. From our literature search, this information doesn’t seem to be available. Rather, there are evaluations of broad programs (such as Keep Well), or specific
primary studies (eg does using MET office information help patients with COPD?). I am aware of one cohort study (n=96) which investigated whether applying an ACP can help to reduce hospital admission rates in older patients who were at risk of admission to hospital (ref.2).

3. Topic Referrer states they are interested in frailty and LTCs, can they be more specific eg are children of interest?