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## CONFERENCE ABSTRACT

# **A novel partnership for proactive person-centred anticipatory care in North Lanarkshire**

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Anticipatory Care is a shift from reactive, fragmented, episodic care to proactive, personalised and coordinated team based care that starts with what matters to the individual and takes an enablement and strength based approach. However in a post Covid-19 landscape many primary care teams are challenged to deliver proactive care for the growing number of people with frailty who will benefit from the approach.

A novel collaborative approach was co-designed with primary care teams, patients and carers in one locality. Information from GP records and the electronic Frailty Index was used to identify individuals with escalating levels of frailty. In addition, professionals could identify individuals opportunistically. Prior to the pandemic, Health Visitors gathered information and performed clinical assessments at home and discussed issues such as Power of Attorney and Anticipatory Care Planning (ACP). The workforce disruption from the pandemic was a catalyst to test new workforce roles. The locality engaged an advocacy service partner to increase capacity for authentic person centred multi disciplinary team (MDT) care for older people with frailty. Other core members of the MDT are GP, geriatrician and pharmacist with support as required from allied health professionals, social care, dietician, community mental health team and third sector.

The approach is goal--orientated ensuring the patient, their wishes and their family or carer remain the primary focus (Steele Gray et al, 2020). The advocacy worker supports the patient through a self assessment process before representing the patient within the MDT discussion, ensuring independent advocacy and support at each stage of the process and enabling the MDT to formulate interventions that are in keeping with the patient's wishes and priorities for their health. Interventions range from polypharmacy reviews to care packages, referrals to other professionals and to social prescribing supports. Following the MDT the patient receives a phone call from the advocacy worker, outlining the proposed interventions and ensuring they are empowered to express their opinion and wishes. Thus the patient remains in control and the team avoids a paternalistic therapeutic approach (Dumez and Pomey, 2019).

Between October 2019 and December 2021, 106 patients were discussed by the MDT. Median age was 78 (range 58 – 101) years, 58% were female and 73% were identified using routine GP data. Seventy had a home assessment and multifactorial interventions, the remainder had an ACP to share their wishes about future care.

An enabler was the use of Microsoft Teams platform. Conducting MDT's virtually allows seamless information sharing in real time for accurate and informed care planning despite health, social care and the third sector operating separate electronic systems.

The advocacy service is now seen as a key partner in the MDT. Working in a transdisciplinary manner helped overcome service pressures. Extending roles outwith normal professional boundaries and across sectors creates capacity for managing frailty, ensures safe, effective and person centred care and enables relational practice and reciprocal learning (Batorowicz and Shepherd, 2008). The novel collaborative approach is now being rolled out across other localities.